Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 2008 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) December 30, 2008 **Physician** 9:52 P M Richard William Auth /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 639 Westwood Drive Harford Aberdeen If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) 11/16/1932 5. Social Security Number 6. Sex 1 M 2 ☐ F 7. Age (In yrs. last birthday) **Funeral** South Dakota 76 Director 289-28-1860 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show at 1 TXYes 2 □ No 7 is marked other than "natural", or items 23a or 28a-f si traumatic event, he Medical Examiner must be notifiled Director Harford MD Aberdeen 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 639 Westwood Drive 21001 U.S.A.

14. Race - American Indian, Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene. 1X Yes 2 No If Yes, Give Year or Dates: Vietnam 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify.White 2 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Military U.S. Army 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Leo Auth UNK ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 st Department of Health an Important: If item 27 is n any Injury or other traur Michael Auth (Son) 750 Concord Point, Perryville, MD 21903 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Arlington Nat. Cemet. 2/12/09 Arlington, VA 4 □ Donation 5 Other (Specify) ral Se vice License 22. Name and Address of Facility
Tarring—Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardiac arrhy thmis **Physician** inneticte /Medical Due to (or as a consequence of): Examiner Libillation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): attending physician and for use as the burial-tran Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an certificate has t autopsy performed? 1 Yes 2 No 25. Was case referred to medical funeral director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 5 Pending To the Hospital or Attendir within 24 hours after death.
To the Funeral Director: All completely filled in by the fu 1 Yes 2 No death. investigation 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

5+1

PATRICIA 31. Date filed (Month, Day, Year) State

(Check only one)

29b. Signature and title of certifier

65 W. M-c Phail Rd DUBSOIL 32. Registrar's Signature

mo

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year) 01/02/2009

Bel Air MO ZLOLY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** December 18, 2008 Evelyn Jane Alger /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Washington Fahrney-Keedy Home & Village Boonsboro Hours Min. 8. Date of Birth (Month, Day, Nov. 25, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number **Funeral** 1 □ M 2 🕽 F Days 87 577-24-5816 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Mydical Examiner must be notified at once. 1 ☐ Yes 2 🛣 No Directo MD Washington Keedysville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 19292 Shepherdstown Pike 21756 by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐Yes 2X☐No Specify: Specify: White 3 Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Clerk Grocery Store 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Beatrice Martha Snapp John Hesbia Foster 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 19292 Shepherdstown Pike - Keedysville, MD 21756 <u> Linda C. Hynen - Daughter</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Fairview Lutheran Cem, 12/22/08 Bolivar, WV 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Eackles-Spencer & Norton Funeral 21. Signature of Funeral Service Licenses Roll & | Home - Harpers Ferry, WV 25425 M970 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Q **Physician** /Medical Due to (or as a con equence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dure to (or as a consequence of) Examine ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 s autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2XXNo Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Skinursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 21 ☐ XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

State Registrar

4 Homicide

(Check only one)

29b. Signature and title of certifier

<u>Khalid Waseem,</u>

29a. Certifier

Medical

Evelyn

1126 Opal Court - Hagerstown, MD 21740

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD -

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D(2)23

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 2 0 0 8 Certificate of Death Reg. No. 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** ANDERSON ANNA 26 4:52 PM 2008 DEC /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner CHARLES GENESIS LA PLATA CENTER LA PLATA If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
DEC.3, 1928 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Min. 1 □ M 2 🔀 F Months MARYLAND Director 212-24-4069 80 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits is and 2 should be filed within 72 mem.
I Health and Mental Hygiene.
Item 27 is marked other than "natural", or Items 23a or 28a-f show item 27 is marked other than "natural", or Items 23a or 28a-f show item 27 is marked other than "natural", or Items 23a or 28a-f show item 27 is marked other than "natural", or Items 23a or 28a-f show items 23a or 28a 1 ☐ Yes XXNo Director MD CHARLES WALDORF 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12168 GILLESPIE CIRCLE 20602 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc. 1 ☐ Never Married 2 ☐ Married 21215-0036 1 ☐ Yes 2 🔀 No Specify. ģ Specify: WHITE 3 ₩idowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 NEWSPAPER SALES Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be HERBERT K. BREEDEN PEARL K. JAMES 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any Injury or other trau DAVID ANDERSON/SON 210 MATT DILLON TRAIL CENTRAL, UTAH 84722 altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2☐Cremation 3 ☐ Removal from State METROPOLITAN CR. 4 ☐ Donation 5 ☐ Other (Specify) 31,2008 ALEXANDRIA, VA 22. Name and Address of Facility RAYMOND FUNL. SERVICE, P. A. 5635 WASHINGTON AVE., LA PLATA, MD 20646 M00641 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical r as / consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine nding physician and use as the burial-transit The law requires that the death certificate be executed Box 68760, au Physician/Medical 23c. If yes, outcome of pregnancy

1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant atten for us 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 5 ☐ Other (specify) signed by the a P.O. 9 Unknown 9 Unknown nificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed nemil 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 1 □Yes 2 No or Attending Physician: 25. Was case referred to medical funeral director Be 26. Place of Death (Check only one) examiner? Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending ours after death.

neral Director: At filled in by the fur investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier To the Hosp within 24 hou To the Funer completely fil Medical and manner stated 29b. Signature and title of certifig 29d. Date signed (Month, Day, Year) 121031 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Old Line ( enter Sud 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

**ORIGINAL** 

DHMH 17 Rev 1/2001

08-09686 David Earl Brown

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 43004

		For State	(	Certificate of	Death			Reg. No.	
Physician		egistrar . Decedent's Name (First, Middle,Last	t)				2. Date of De Month	Day Year	3. Time of Death 1206 hrs
ledical Examine	er	DAVID KARL B				=	Decembe	er 24, 2008	
	4	a. Facility Name (if not institution, give 3911 Wintergreen Place	e street and number)		4b. City, Town, Waldorf	or Location of De		4c. County of De. Charles	
Funeral .	5	. Social Security Number 6. Se	ex 7. Age (In	yrs. last birthday)	If Under 1 Y		-	irth (MM/DD/YYYY) 9.	Birthplace (State or Foreign Country)
Director	L		M 2 F	46 Yrs	Months D	ays Hours	8-20-		ARÝLAND
	_	Isual Residence of Decedent  0a. State 10b. County	I10c	City, Town or Locat	tion		- FOI 2		10d. Inside City Limits
ow any	1	0a. State 10b. County CHARLE		Oity, Tomico Lasse.	WALDO	RF			1 Yes 2 XNo
Aaryland 28a-f show Latonce,	5 -	0e. Street and Number			10f. Zip Code	е		10g. Citizen of What C	ountry?
hours after death with the Maryland 'natural', or items 23a or 28a-f sho Eataminer must be notified at once.	֓֟֟֓֟֓֟֓֟֓֟֓֓֓֓֟֓֓֓֓֟֓֓֓֓֓֟֓֓֓֓֓֓֓֓֓֓	3911 WINTERGR	REEN PLACE			0602		U.S.A.	
ms 23		1. Mantal Status	12. Was Decedent Ever Armed Forces?			Hispanic Origin? ban, Mexican, Pu	(Specify Yes or Nerto Rican, etc.)	No- , 14: Race - An White, etc	nerican Indian, Black,
or ite	7	1 X Never Married 2 Married	1 XYes 2	No	Yes 2 X			Specify: TAT	HITE
rs afte	- ۵	Widowed 4 Divorced     Divorced     Specify or Divorced	If Yes, Give Year 198 or Dates:	ed) 16a. Decede	nt's Usual Occu	pation (Give kind	of work done	16b. Kind of Busine	
5-0036 led within 72 hours Hygiene. to other than "natur the Medical Exami		Elementary/Secondary (0-12)	College (1-4 or 5+)	during n	nost of working	life. DO NOT use	retired) -		
136 thin 72 ne. than "edical	Complete	12th		CONS	STRUCT	ION WOR		SELF EM	PLOYED
15-003( filed within al Hygiene. ed other tha t, the Medii		7. Father's Name (First, Middle, Last	.)					e, Maiden Surname)	
21 be fi	8	KENNETH ELBER		40L Maille	- Address (O	MYRTI	E ALICI	E ZOLLINH lumber, City or Town, S	OFER
Should and Me is me is me	^ا≏	19a. Informant's Name/Relationship (T SHARON SCHUTT-		1					L,MD. 20622
, MD ind 2 sho calth and em 27 is	-	20a, Method of Disposition		20b. Place of Dispo	sition (Name of		Date	20c. Location - City	
Baltimore, MD 2 bernit. Pages I and 2 shou Department of Health and N Important: If item 27 is in njury or other traumate	1.0	1 Burial 2 X Cremation 3	Removal from State	crematory or o		₽₩₯₽₽₽₽₽₽₽₽₽₽₽₽₽₽₽₽₽₽₽₽₽₽₽₽₽₽₽₽₽₽₽₽₽₽₽	7 12_28.	-08 ALEX.	VA
Tage Fa		4 Donation 5 Other Specify  21. Signature of Funeral Service Licer	/:		Name and Add		. 12-20	- 40 ADDA.	, va.
Balt permit. Depart Impor injury	- 1	~ // . 1 //	//	( /   1	NOMVA	D FUNER	AL SER	VICE, P.A.	
Physician	+	23a. Part I. Enter the disease, or comp	plications that caused the	death. Do not enter	the mode of dy	ing, such as card	iac or respiratory	arrest, shqck, or heart	Approximate Interval Between Onset and
/Medical		failure. List only one cause on e	ach line. , Intraoral Gunshot \					H III 0004	Death
kaminer		or condition resulting in death)	Due to (or as a conseque	ence of):		4			
		Sequentially list conditions, if any, leading to immediate	Due to (or as a conseque	ence of):		-			
	in line	cause Enter Underlying Cause (Disease or injury that initiated	s						
1. H = =		events resulting in death) Last	Due to (or as a conseque	ence of):					
		UNPENDED X	AMENDED #1 a.	s noted p	er ME,	g887 1/2	20/09 TT		
760, icate be e g physicial the burial	Medical	IF FEMALE:	23c. If yes, outcome of					23d. Date of de	livery
	١	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 F	Fetal death	3 Ectopic p	regnancy	Month	Day Year
Division of Vital Records, P.O. Box 68 tall or attending Physician: The law requires that the death certifus all birector: After this certificate has been signed by the at ending led in by the funeral director, page 2 should be detached for use as	'sician/	1 Yes 2 No 9 Unknow	4 Pregnant at tim	e of death 5	Other (Specify)			Î	1
Bc he dea	21	Part II. Other significant conditions	9 UINIOWII	it not resulting in the	e underlying car	use given in Part	I. 23e. D	id tobacco use contribu	te to the cause of death?
D.O. that the property of the contract of the	à	Part II. Other significant conditions	S Contributing to dodd be	it not robuiting in an			1	Yes 2 V No 3	Probably 4 Unknown
ts, landres	Completed						24a. W		re autopsy findings available or to completion of cause of
Orc law re has be 2 sho	휌						p	erformed? dea	ith?
Rec The icate	5				26.1	Place of Death (C		es 2 No 1	Yes 2 No
cian:	Be	25. Was case referred to medical examiner?	Hospital: 1 Inpatient	2 ER/Outpatie		Other	Nursing Home 5	Residence 6 🗸	Other: Scene
f Vi Physi er this	의	1 ✓ Yes 2 No 27. Manner of Death	Date of Injury	28h Time o		. Injury at Work?	28d. Descr	ibe how injury occurred	
n o ding ding h Aft	ö	1 Natural 5 Pending	FOUND: Day, Year	FOUND:	1	Yes 2 🗸 N	Subject s	shot self	
isio	icat	2 Accident Investiga	ation Dec 24, 2008	1158 hrs y - At home, farm, st	reet, factory, of	fice building, etc.	28f. Location	on (Street and Number	or Rural Route Number, City
Div	Certification:	Suicide 6 Could no determin		e Family Home			3911 Wint	n, State) ergreen Place, Wald	dorf, MD
Division of Vital Records, P.O. Box 687. To the Hospital or Attending Physician: The law requires that the deatl certifit within 24 hours after death. To the Funeral Director: After this certificate has been signed by the at ending completely filled in by the funeral director, page 2 should be detached for use est	S S	29a. Certifier	ician: To the best of my k	nowledge, death oc	curred at the tin	ne, date and place	e, and due to the	cause(s) and manner a	s stated.
o the	edical	one) 2 Medical Examin	ner:On the basis of examinand manner stated.	ation and/or investi			irred at the time, o		
FSFS	ž	29b. Signature and title of certifier				icense number		December 2	(Month, Day, Year) 5 2008
		Den Wi	in mor			D.C.M.E.		December 2	
5		30. Name and address of person wh			11 Pann St	reet Raltimor	re, MD 21201		
		Donna M. Vincenti, MD	Assistant Medica		TI PEIIII SI	Joer, Dailinion			
St Regist	ate	5555 4 - 5555	Sz. Regisirars	Signature	1				

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 1 - State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** РМ December 15, 2008 8:00 Back David , N . /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Brooke Grove Nursing & Rehab Center Sandy Spring Montgomery 8. Date of Birth (Month, Day, Year, Sept. 30, If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) Year) Months 1 🖾 M 2 🗆 F 88 1920 Connecticut 579-18-5949 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director 1 ☐ Yes 2 ☑ No Maryland Montgomery Sandy Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 18100 Slade School Road 20860 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ★Yes 2 No
If Yes, Give
Year or Dates: ₩₩II 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No Specify à Specify 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Artist / Musician Arts 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Name (First, Middle, Last) Be ဂ္ Ernest Back Clara Newcomb 19a. Informant's Name/Relationship (Type. Frint) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7901 Greentree Road; Bethesda, MD 20817 Cindy Libby Green / Guardian 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemtery 12/29/2008 Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Simple Tribute 1040 Rockville Pike, Rockville, MD 20852 23a. Part 1. Enter the disease shock, or art failure. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, st only one cause on each line. Approximate Interval Between Onset and Death Immediate C use (Final disease or co div on resulting in death) ACUTE KENAL WEEKS Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> DEMENTIA 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No 24a. Was an autopsy perform 2 No 1 ☐Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🚾 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

**Funeral** 

Director

ir than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at

the Maryland

Pages 1 and 2 should be filed within 72 hours after death with

permit. Pages 1 and 2 should be filed witl Department of Health and Mental Hygien Important: If item 27 is marked other tha any Injury or other traumatic event, I and once.

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0036

Completed

Medical

State

Registrar

29c. License number 33700

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) December 15, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N.

and manner stated.

WILLI AMSPORT.

6

29a. Certifier





Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2003 Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death **Physician** December  $P^{M}$ Thao Bounthinh 2008 2:32 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 H 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 5. Social Security Number Birthplace (State or Foreign Country) Days Months Hours 1 XM 2□ F Director 66 March 5, 1942 Laos 577-86-8928 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show r than "natural", or items 23a or 28a-f shov the Medical Examinar must be notified at 1 ☐Yes 2X No Director Silver Spring Maryland Montgomery 10e. Street and Number 10g. Citizen of What Country? 12911 Summer Hill Dr 20904 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 🔀 Married Baltimore, Maryland 21215-0036 1 □Yes 2 📆 No Specify: 3 Widowed 4 Divorced Asian 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Fairfax County Elementary/Secondary (0-12) College (1-4or 5+) Government nd 2 should be filed wath and Mental Hygies 27 is marked other the traumatic event, Ill. Substance Abuse Counselor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev 2 Thao Sang Lila Sang 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12911 Summer Hill Dr, Silver Spring, MD 20904 Lien Ngoc Hang/Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Memorial Park Dec 28, 2008 Rockville, MD 22. Name and Address of Facility Hines-Rinaldi Funeral Home 21. Signature of Funeral Service License Nance 11800 New Hampshire Ave, Silver Spring, MD 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedial ause (Final diseas or condition resulting in death) Physician Cerebrovascular Accident /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed and burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical the as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 s autopsy performe 2 X No 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 ☐ Pending investigation To the Hospita or within 24 hours after death.

To the Funeral Director; Aff 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 18 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Rd, Silver Spring, MD 20910 Ashish Tolia, MD

State

Registrar

31. Date filed (Month, Day, Year)

DEC

2 4 2008

Règistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 2008

43007

Physician
/Medical
Examiner

Funeral **Director** 

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23 or 28a-f show any Injury or other traumatic event, If a Macifical Eventher must be notified at anones.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

## Ethel Rios de Betancourt  ## (Indirection   Day   Pear   ## (Indirection   Day   Day   Day   Day   ## (Indirection   Day   Day   Day   Day   Day   Day   Day   Day   ## (Indirection   Day   Day   Day   Day   Day   Day   Day   Day   ## (Indirection   Day   Day   Day   Day   Day   Day   Day   Day   Day   ## (Indirection   Day   ## (Indirection   Day   ## (Indirection   Day	
## Fether Rios de Betancourt  4a. Fatily Name (from Installation, pive area and number)  4b. Fatily Name (from Installation, pive area and number)  5b. Section Security Number  10. Section Section Security Number  10. Section Secti	ne of Death
Renaissance Gardens at Riderwood Village  Social Security Number  1.03 - 2.2 - 8.721  1.04 2 (2x) 7. Age (in yes hast brinday)  1.05 - 2.2 - 8.721  1.06 2 (2x) 7. Age (in yes hast brinday)  1.06 2 (2x) 7. Age (in yes hast brinday)  1.06 2 (2x) 7. Age (in yes hast brinday)  1.06 2 (2x) 7. Age (in yes hast brinday)  1.06 2 (2x) 7. Age (in yes hast brinday)  1.06 2 (2x) 7. Age (in yes hast brinday)  1.06 2 (2x) 7. Age (in yes hast brinday)  1.06 2 (2x) 7. Age (in yes hast brinday)  1.06 2 (2x) 7. Age (in yes hast brinday)  1.06 2 (2x) 7. Age (in yes hast brinday)  1.06 2 (2x) 7. Age (in yes hast brinday)  1.06 2 (2x) 8. Age (in yes hast brinday)  1.07 2 (2x) 8. Age (in yes hast brinday)  1.08 2 (2x) 8. Age (in yes hast brinday)  1.08 2 (2x) 8. Age (in yes hast brinday)  1.08 2 (2x) 8. Age (in yes hast brinday)  1.08 2 (2x) 8. Age (in yes hast brinday)  1.08 2 (	26 p
Renaissance Gardens at Richerwood Village  5. Social Security Number  1.03-02-78721    County   Social Security Number   County Number   Social Security	_ U P
Society Number   G. Sex   T. Age (in yes. last brandary   Months   Days   House Alth   B. Ober of Egint   New York   No. Cooling   New York   No. Cooling   New York   No. Cooling   New York   No. Cooling   New York   N	's
103-22-8721   Close   S2   Yrs.   Moorth   Day   Mours   Day   No.   (Morth, Cay, Na.)   No.   (Morth, Cay, Na.)   No.   No.   No.   No.   You	
Top   State   Top   To	
Maryland   Montgomery   Silver Spring   10g. Citizen of What Country?   20904   2090	de City Line
Security	
11.1 Maria Status	Yes 2
1.1. Marital Status   12. Wes Decedent Ever in U.S.   1.3. Was Decedent of Hispanic Croppt* (Specify Ye is or Not Press, 2 12 No. Specify: Puer to Rica.   1.4. Resp. Ammed Force; 1.1. Yes. 2 12 No. Specify: Puer to Rica.   1.5. Decedent's Education   1.5. Decedent's Usual Cocupation   1.5. Decedent's	
Type s, specify Cuban/ Mexican, Pearlt Richae, etc.)   Specify Puerto Rican   Specify Pue	
1   Newer Married   Newer   Married   Newer	ın,
15. Decedent's Education   16. Kind of BusinessIndustry   16. 16. Kind of Busi	
College   Professor   Education   Secondary (0-12)   College   College   Horisty   Secondary (0-12)   College   Professor   Education   Structure   Secondary (0-12)   Secondary (0-12	
Elementary/Secondary (0-12)   College (1-for 5+)   College Professor   Education	
19. Mother's Name (First, Middle, Last)   19. Mother's Name (First, Middle, Maiden Surmame)   19. Mother's Name Relationship (Type Print)   19. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Arturo E. Betancourt/Son   14721 Silverstone Drive, Silver Spring, MD   14721 Silverstone Driver Spring, MD   14721 Silverstone Driver Spring, MD   14721 Silverstone Driver Spring, MD   14721	
Fleuterio Rios Cruz	
19a. Informant's NamerRelationship (Type Print)  Arturo E. Betancourt/Son  14721 Silverstone Drive, Silver Spring, MD  20a. Method of Disposition 1	
Arturo E. Betancourt/Son   14721 Silverstone Drive, Silver Spring, MD	
20a. Method of Disposition 1   Durial 2   20   Creamation 3   Removal from State   Metropolitan Crematory or other place)   Due to	
Support   Supp	20903
Alexandria   Vir   Alexandria	te
23a. Part 1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.    Part 1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interest shock, or heart failure. List only one cause on each line.    Part 1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interest shock, or heart failure. List only one cause on each line.    Part 1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interest shock, or heart failure. List only one cause on each line.    Part 2. Enter the death of the past 12 months?   Due to (or as a consequence of):	ainis
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, immediate Cause (Final Institute). List only one cause on each line.  Due to (or as a consequence of):  23d. Date of delivery month Day  1   Nonth Day  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of performance of performance of the cause of performance of the cause	Этита
23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.    Immediate Cause (Final disease or conditions in death)   Due to (or as a consequence of):	MD 2
shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last    IF FEMALE: 23b. Was decedent pregnant in the past 12 months?   Use to (or as a consequence of):	
Sequentially list conditions   Due to (or as a consequence of):	Between and Death
Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  C. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  c. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  d. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  e. Due to (or as a consequence of):  d. Due to (or as a consequence of):  d. Due to (or as a consequence of):  e. Due to (or as a consequence of):  d. Due to (or as a consequence of):  e. Due to (or as a consequence of	and Death
Lating in death) Last  C. Due to (or as a consequence of):  d.     IF FEMALE:   23b. Was decedent pregnant in the past 12 months?   1   Yes   2   Zimon   2   2	
Lating in death) Last  C. Due to (or as a consequence of):    Due to (or as a consequence of):	
Lating in death) Last  C. Due to (or as a consequence of):  d.     IF FEMALE:   23b. Was decedent pregnant in the past 12 months?   1   Yes   2   Zimon   2   2	
Due to (or as a consequence of):    IF FEMALE:	
23b. Was decedent pregnant in the past 12 months?  1	
23b. Was decedent pregnant in the past 12 months?  1	
23b. Was decedent pregnant in the past 12 months? 1   Live birth 2   Fetal death 3   Ectopic pregnancy   Month Day    Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23c. Place of Death   Live birth   Live	
in the past 12 months? 1   Yes 2   St No 9   Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of the	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of the contribution of the cause of the contribute to the cause of the contribution of the cause of the ca	Year
1   Yes   2   No   3   Probably	
1   Yes   2   No   3   Probably	of death?
24a. Was an autopsy performed? 1   Yes 2   No   24b. Were autopsy find prior to completic death? 1   Yes 2   No   1   Yes 2   No   1   Yes 2   No   1   Yes 2   No   No   Nursing Home 5   Residence 6   Other (Specify)  27. Manner of Death 1   Natural   5   Pending investigation   28a. Date of Injury   28b. Time of Injury   28b. Time of Injury   28c. Injury at Work?   1   Yes 2   No   Nursing Home 5   Residence 6   Other (Specify)  28a. Date of Injury - At home, farm, street, factory, office   28f. Location (Street and Number or Rural Routh City or Town, State)  29a. Certifier (Check only 2   Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
autopsy performed? 1   Yes 2   No   No   Nursing Home   S   Residence   S   Residence   S   No   S   No   S   No   Nursing Home   S   Residence   S   No   Nursing Home   S   Residence   S   No   S   Nursing Home   S   Residence   S   Nursing Home   S   Nursing	
25. Was case referred to medical examiner?   26. Place of Death (Check only one)   1   Yes   2   Mo   1	ngs availab
25. Was case referred to medical examiner?    Yes   2   No	
1   Yes 2   No   Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other: 4   Nursing Home 5   Residence 6   Other (Specify)    27. Manner of Death 1   Natural 2   Accident 3   Suicide 4   Homicide   1   Could not be determined   28a. Date of Injury - At home, farm, street, factory, office   28f. Location (Street and Number or Rural Route City or Town, State)    29a. Certifier (Check only 2   Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
27. Manner of Death  1 🕱 Natural  2 Accident  3 Suicide  4 Homicide  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  28a. Date of Injury  28b. Time of Injury  28b. Time of Injury  28c. Injury at Work?  1 Yes 2 No  28d. Describe how injury occurred	-
2 Accident 3 Suicide 4 Homicide  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rural Route City or Town, State)  29a. Certifier (Check only)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause (s) and manner as stated.	
3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  29a. Certifier (Check only 29a. Certifier (Check only 29b. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
29a. Certifier  (Check only   1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	Number
(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the call	
(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the call	
and mariner stated.	ise(s)
20h Cignotius and title of portifier /	
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Young December 30,	ar) 2008
Loven ranking, MD D59524	_000
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	
Loveen Puthumana, MD 3110 Gracefield Road, Silver Spring, MD 20904	

Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar AMEND#23 openMD12/24/08, BWW, MoCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Ervin Bognar 12/22/2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bethesda If Under 1 Year | If Under 24 Hrs. 8323 Still Spring Crt Montgomery 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number **Funeral** Min. 1X M 2□ F Months Davs Hours 212-98-9646 Director June 02,1911 Hungaray Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Health and Mental Hyglene. sair. If item of 21 km arted other than "natural", or items 23a or 28a-f shounty or other traumatic event, is "Marice Exv." is an unit to notified. 1X Yes 2 □ No Director MD Bethesda Montgumery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral United States 8323 Still Spring Court 20817 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. □Yes 2 Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. 2 Specify 3 X Widowed 4 □ Divorced Year or Dates White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Engineer <u>Textile</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Jeono Bognar un known 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Guillermo Yepes/ son in law</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Judean Mem. Grdn. Dec.23,2008 Olney MD 22. Name and Address of Facility 1170 Rockville Pike Rockville MD 20852 21. Signature of Funeral Service Licensee Danzansky-Goldberg Mem. Chpls 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician PIRATIO disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to ministrate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a ronsequence of): Physician/Medical Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 3 Probably 4 Unknown 1 ☐ Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy death? 1 ☐ Yes 2 No 1 □Yes funeral director, 25. Was case referr to medica examiner? 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natura 5 Pending investigation hours after death. neral Director: Af y filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide 24 hours a 1 👺 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical To the Hosp within 24 ho To the Fune completely f 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie

Registrar
DHMH 17 Rev 1/2001

State

0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

32 Registrar's Signature

AL

Year,

4

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 43009 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 12 Day 22 **Physician** RUTH BRITTINGHAM 0720 A M 08 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner WICOMICO 9288 HICKORY MILL DRIVE SALISBURY 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2**X** F Days Hours Director 2-16-1922 221**-**16**-**93<u>39</u> 86 DELAWARE Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show the Medical Examiner must be notified at Director 1 ☐ Yes 2 No DELAWARE SUSSEX **MILLSBORO** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 310 WARWICK ROAD 19966 US Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō Specify: WHITE 1 ☐ Yes 2X No Specify: ģ 3 X Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Magnone. Elementary/Secondary (0-12) College (1-4or 5+) BOOK KEEPER **BLOCK COMPANY** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be FRANK PARKER MILDRED LOWE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LEON O. BRITTINGHAM, JR/SON 509 SOUTH OLD MILL RD, DOVER, DE. 19901 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 Deremation 8 Removal from State MILLSBORO CEMETERY 12-28-08 MILLSBORO, DELAWARE 4 Donation 5 Other (200 c)(y) 21. Signature of Funeral Se 22. Name and Address of Facility MELSON FUNERAL SERVICES, LTD 32013 LONG NECK RD, MILLSBORO, DE. 19966 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or es a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Due to (or es a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 C Ectopic pregnancy Month Day Year 5 Other (specify) Division of Vital Records, P.O. sate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably Munknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2/2No 1 ☐Yes 2 ☐No 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) ASSISTED 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this HVING 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation death. 1 ☐Yes 2 ☐No 2 Accident Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only one) 24 within 2 To the I 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BN8 614 31. Date filed (Month, Day, Year) 32. Begistrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 10-40 AM December 2008 MARY JANE BARRETT 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye 2/3/1924 9. Birthplace (State or Foreign 5. Social Security Number Hours Months 1 □ M 2 😿 F Days Columbia NC 240-32-3301 84 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1X Yes 2 □ No Carroll New Windsor MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1600 Greenwood Church Road 21776 **USA** 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2X No Specify Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Homemaker Housewife 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mittie Brickhouse Archie Swain 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Christine Shoemaker Grand Daug. 1600 Greenwood Church Rd New Windsor MD 21776 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 12/26/2008 Meadowridge Mam Park 4 ☐ Donation 5 ☐ Other (Specify) Elkridge MD 21. Signal Fuleral Service Lightney

Barbara A Williams 22. Name and Address of Facility John T Williams Funeral Home, Brunswick MD 21716 Approximate Interval Between Onset and Death Hould 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Cardio Kes Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2XER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

Director

Funeral

2

Completed

Be

ဂ

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. In Innortant: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any lojury or other traumatic event, Ite Medical Exp. it is a must be realtied and Dece.

Baltimore, Maryland 21215-0036

and attending physician for use as the buria

within 24 hours aft

To the Funeral Di

completely filled in

the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

Exam
/Med
leted by Physician/Medical
Phys
ed by
mplet
e Co
To B
ation: To Be Comple
rtifica
ပီ

3 Suicide 4 Homicide

29a. Certifier

29b. Signature

6 ☐ Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

— Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print) 196 TJ DLIVE,

and manner stated.

32. Registra's Signature 31. Date filed (Month, Day 2008 ▶

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** December 2008 Thomas **Black** /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Frederick Frederick 10181 Winston Drive Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Social Security Number **Funeral** Months Days Hours t★ M 2 F Yrs October 22, 1930 **Alabama** 421-36-6078 78 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any lijury or other traumatic event, the Medical Exscriment must be notified any once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Frederick 1 ☐ Yes 2 No Frederick **Maryland** Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21701 10181 Winston Drive Funeral Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Xes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married white 1 ☐ Yes 2 🛣 No Specify þ 3 X Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Medical Medical Technician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Cordie Dillard Walter T. Black ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10181 Winston Drive, Frederick, Maryland Michael Black - son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Removal from State 12-19-2008 Frederick, Maryland Resthaven Memorial 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stauffer Funeral Home 21. Signature of Funeral Service Licensee 1621 Opossumtown Pike, Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** UAS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Completed by Physician/Medical Be

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

	d						
IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown	23d. Date of delivery Month Day Year						
Part II. Other significant conditions	23e. Did tobacco	co use contribute to the cause of death?					
Hy outening	79			1 □ Yes _2	No 3 Probably 4 Unknown		
Dita betas!	nullitus Typ	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  o 1 □ Yes 2 □ No				
25. Was case referred to medical			26. Place of De	ath (Check only one)			
examine/?	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	DOA Other: 4 Nursing I	ome 5 Besidence 6 ☐ Other (Specify)			
27. Manner of Death  1	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how inju	ury occurred		
3 ☐ Suicide 6 ☐ Could not be determined		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier CertifyIng P	hysician: To the best of my known miner: On the basis of examinating and manner stated.	owledge, death occurr ation and/or investigat	ed at the time, date and plaction, in my opinion, death occ	ce, and due to the cause( curred at the time, date ar	s) and manner as stated. nd place, and due to the cause(s)		

29c. License number

00145

State Registrar

Medical Certification: To

MO

21701

29d. Date signed (Month, Day, Year)

Casper Cline, MD 31. Date filed (Month Pay Year)

29b. Signature and title of certifier

30. Name and address of person who complete

cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Lest) **Physician** Bullis Jr. December 23, 8:55 Carl 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Worcester Berlin 11733 Grays Corner Road If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Months Days Hours Min. 1 X M 2 □ F 54 214-66-2576 8/28/1954 Washington, DC **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shot traumatic event, the Mode of Eramina, must be reciliable 1X Yes 2 No Director Berlin Worcester Maryland death with the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 23a or USA 21811 11733 Grays Corner Rd. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify Specify: white ş 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 h and Mental Hygiene. 7 Is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) food service cook 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ardell Young Carl Bullis Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11733 Grays Corner Rd., Berlin, MD 21811 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 st Department of Health an Important: If Item 27 Is n any injury or other traun Helen E. St. John/fiancee 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Salisbury, MD Salisbury Crematory 12/26/08 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Thorrowd Adversal Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 1621 Danne 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cluse on each line. Approximate Interval Between Onset and Death ailur Immediate Cause (Final esticator **Physician** disease or condition resulting in death) /Medical Mon Small COU (or as e consequ (anca Examiner Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events Examine The law requires that the death certificate be executed for use as the burial-trans and resulting in death) Lest Due to (or as a consequence of) attending physician Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) P.O. I signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown s peen s 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has funeral director, page 2 s autopsy 1 ☐ Yes 2 🗹 No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Division 5 ☐ Pending investigation spital or Attendii ours after death. neral Director: A death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital of 24 hours al To the Hospital within 24 hours a To the Funeral C 🖊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 08

State Registrar 31. Date filed (Month, Day, Year)

32. Registray's Signature

Wallet.

2008

1 - State Registrar Certificate of Death Reg	ene No.2008 43013			
1. Decedent's Name (First, Middle, Last)  2. Date of Death Month	Day Year 3. Time of Death			
Physician Carl Lee Brown December	29, 2008   2317 P <sup>M</sup>			
/Medical Examiner  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	4c. County of Death			
Union Hospital Elkton	Cecil Cecil			
Funeral 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Y	(ear) 9. Birthplace (State or Foreign Country)			
Director 215-34-1817 /0 NOV 27, 1	1938 Maryland			
Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits			
Elkton	1 ☐ Yes 2 No			
Maryland Cecil Elkton  10c. Street and Number 10g.	. Citizen of What Country?			
62 Otter Point Road 21921	United States			
62 Otter Point Road  12. Was Decedent Ever in U.S.  13. Was Decedent Of Hispanic Origin? (Specify Yes or No-	14. Race - American Indian,			
62 Otter Point Road  11. Marital Status  1  Never Married  1  Never Married  2	Black, White, etc.			
Yes, Give 1 ☐ Yes 2 ▼ No Specify:	Specify: White			
Process of the part of the par	b. Kind of Business/Industry			
College (1-4or 5+)  Elementary/Secondary (0-12)  Elementary/Secondary (0-12)  Maintenance	D1			
The secondary (0-12)   College (1-40r 5+)   Maintenance   11   The state is Name (First, Middle, Last)   18. Mother's Name (First, Middle, Maintenance   18. Mother's Name (Fi	Plastic			
The state of the	iden darname)			
The state of the s	City or Town State Zin Code)			
19a. Informant's Name/Relationship (Type. Print)  Anna Brown/Wife  19b. Mailing Address (Street and Number or Rural Route Number, of the street and Number of the street and Number or Rural Route Number of the street and Number of the street and Number of the street and Number or Rural Route Number of the street and Numb				
	Oc. Location - City or Town, State			
January 3,	Ellet MD			
	Elkton, MD			
21. Signature of Funeral Service Licensee  22. Name and Address of Facility.  Hicks Home for Funerals, P. 103 W. Stockton Street, Elki	A. ton, MD 21921			
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arres shock, or heart failure. List only one caus on each line.	t, Approximate			
Immediate Cause (Final	Onset and Death			
/Medical disease or condition resulting in death) a. Due to a consequence of):	7.00			
Examiner by Schemic Cardiomyopomy	years			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events are consequence of the cause (Disease or Injury that initiated events).	Stares IPA			
if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):	DISEASE YCENY			
Causée. Enter Underlying Causée. Enter Underly				
dical				
	23d. Date of delivery			
S of the second program of the past 12 months?    S of the second program of the past 12 months?   23c. If yes, outcome pf program of the past 12 months?   23c. If	Month Day Year			
Solution of the part of part o				
So the poly serious se	bbacco use contribute to the cause of death?			
sy se	s 2 No 3 Probably 4 Unknown			
0 > 0 0   P   P   O 0   SP-7// P   24a. Was an	24b. Were autopsy findings available			
So a se	autopsy prior to completion of cause of performed? death?  1□ Yes 2 ♣ No 1□ Yes 2□ No			
= £ 2 €   0   1/1 DOLOG   1/P/1/1 +1 1C   1   Yes 2	MINO ILITES ZLINO			
The second of th				
1   Yes   2   25. Was case referred to medical examiner?   1   Yes   2   25. Was case referred to medical examiner   1   2   25. Was case referred to medical examiner   1   2   25. Was case referred to medical examiner   1   2   25. Was case referred to medical examiner   1   2   25. Was case referred to medical examiner   1   2   25. Was case referred to medical examiner   1   2   25. Was case referred to medical examiner   1   25. Was case referred to medical examiner   1   25. Was case referred to medi	)			
To the second part of the second	nce 6 □Other (Specify)			
To   To   To   To   To   To   To   To	oce 6 Other (Specify)			
To the first of th	oce 6 □Other (Specify)  vinjury occurred  seet and Number or Rural Route Number,			
1   Yes   2   25. Was case referred to medical examiner?   1   Yes   2   25. Was case referred to medical examiner?   1   Yes   2   No   Hospital:   1   Inpatient   2   ER/Outpatient   3   DOA   Other:   4   Nursing Home   5   Resident   1   Yes   2   No   1   Yes   2   No   No   No   No   No   No   No	nce 6 □Other (Specify) vinjury occurred eet and Number or Rural Route Number, State)			
To the part of the	nce 6 □Other (Specify)  vinjury occurred  set and Number or Rural Route Number, State)  use(s) and manner as stated.			
The continue of the continue	nce 6 □Other (Specify)  vinjury occurred  set and Number or Rural Route Number, State)  use(s) and manner as stated.			
Natural   2   Accident   3   Suicide   4   Homicide   5   Pending investigation   5   Pending investigation   6   Could not be determined   28e. Place of injury - At home, farm, street, factory, office   28f. Location (Street, factory)   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   No	ace 6 □Other (Specify) vinjury occurred  set and Number or Rural Route Number, State)  use(s) and manner as stated. te and place, and due to the cause(s)			
1   Yes   2    25. Was case referred to medical examiner?   1   Yes   2    No   Hospital:   1   Inpatient   2   ER/Outpatient   3   DOA   Other:   4   Nursing Home   5   Resider   Resider   1   Yes   2   No   Injury   28b. Time of   Injury   28	ace 6 □Other (Specify) vinjury occurred  set and Number or Rural Route Number, State)  use(s) and manner as stated. te and place, and due to the cause(s)			
Natural   2   Accident   3   Suicide   4   Homicide   5   Pending investigation   6   Could not be determined   28e. Place of injury - At home, farm, street, factory, office   28f. Location (Street, order of the country of the co	ace 6 □Other (Specify) vinjury occurred  set and Number or Rural Route Number, State)  use(s) and manner as stated. te and place, and due to the cause(s)			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 43014 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** A M Larry W. Brown December 2008 0824 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Cecil Union Hospital E1kton If Under 1 Year 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In vrs. last birthdav) 5. Social Security Number **Funeral** Months Days Hours Min. 1 🗓 M 2 🗆 F 222-38-1156 April 17, 1953 Virginia Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mertal Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show my or other traumatic event, Ir. Medical Exacts we must be notified at ury or other traumatic event, Ir. Medical Exacts we must be notified at 10d. Inside City Limits 10a. State 10h County 10c. City. Town or Location 1 ☐ Yes 2 🔽 No Director Cecil E1kton Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 155 Augustine Herman Highway 21921 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ₹ No Specify. Completed by 3 ☐ Widowed 4 🏋 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electrician Residential/Commercial 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Luther M. Brown Beatrice J. Taylor ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 Is any Injury or other trau once. Kathy L. Baker/Sister Fair Hill Road, Elkton, MD 21921 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition December 1 ☐ Burial 2 🕅 Cremation 3 ☐ Removal from State R. A. Ferris & Co., Inc. 4 ☐ Donation 5 ☐ Other (Specify) 129, 2008 West Chester, PA Hicks Home for Funerals, P.A.
103 W. Stockton Street, Elkton, MD 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Cardine Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, $^\circ$ Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 D Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒No 24a. Was an s certificate has birector, page 2 sl autopsy performe 1 ☐Yes 2 No director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation after death.

I Director: Af
d in by the fur 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours aft

To the Funeral Di

completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 08 65902 MP Carlo E. Gopez, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cathedril Street 3 8

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JAN 1 2 2009

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** AM Wallace R. Bramble 12/30/2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Dorchester General Hospital Cambridge Dorchester If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral**  Date of Birth (Month, Day, Year) 1 M 2 □ F Months Days Hours Min. Director 220-03-0035 85 3/10/1923 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Exercises rough by notified at 1 ☐Yes 2 No Director Dorchester Maryland Cambridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 30 Algonquin Rd. 21613 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 'natural', or 1 ☐Yes 2 No Specify ģ Specify. 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 1943- 1945 White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Communications 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be မ Reuben Bramble Lola Jones 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Richard R. Bramble / Son 27293 Heritage Ct., Salisbury, MD 21801 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ■ Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 1/5/2009 Maryland Veterans Cemetery Hurlock, MD Signature of Funeral Service Licensee 22. Name and Address of Facility urraa Willer Curran-Bromwell Funeral Home, P.A., 308 High St., Cambridge. MD 21613 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Aspirata Immediate Cause (Final disease or condition resulting in death) recurrice **Physician** /Medical Due to (or as a consequence of): Examiner drone Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Exami attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical yes, outcome of pregnancy

Live birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) detached 9 Hinknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? s certificate has birector, page 2 s autopsy performed 1 ☐ Yes 2 ÛNQ 1 □ Yes 2 🗚 30 funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one Be Hospital: 1 Department 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ∐Yes 2 PANo Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No after deat filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Funeral L TE Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) within 2. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CATARINGE MD 21613 14+1 NOMAN 7 HANNY 3 50 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 1 2 2009 Registrar

Brample, Wallace

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

		1	For State Registrar	State of Maryland / De	epartment of Health and Certificate of Death		giene 2008 Reg. No.	43016
			1. Decedent's Name (First, Middle, Las	1)		2. Date of De.	ath Day Year	3. Time of Death
	Physicia	_	Cornelia Colgan			Decembe		7:55 P. M
5	/Medic Examin		4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location of Dea		4c. County of Dea	th
			St. Vincent Care	Center	Emmitsburg		Frederi	
	Funeral		<ol> <li>Social Security Number 6. Se</li> </ol>	7. Age (In yrs. last birtho	Months Days Hours Mir	n. (Month, Da	y, Year) Co	thplace (State or Foreign country)
	Director		042-44-9562	93 Yr	S.	Sept. 2	.6, 1915 M	aryland
	and *		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town o	or Location			10d. Inside City Limits
	Aaryii eho	5		. 1 F	1			1⊠Yes 2□No
	28a-	Director	MD. Freder  10e. Street and Number	ick Emmits	10f. Zip Code		10g. Citizen of What Co	ountry?
	tiled within 72 hours after death with the Maryland Hygiene wher then "natural", or iteme 23a or 28a-f ehow with the Medical Eracidizar must be notified at			A	21727		U.S.A	
	ne 23	Funerai	335 South Seton 11. Marital Status	12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin?	(Specify Yes or No	- 14. Race - Ami	
10	fler d	표	1 ⊠ Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🛣 No	If Yes, specify Cuban, Mexican, Pue	erto Rican, etc.)	Black, Whi	te, etc.
ဗ္ဗ	urs a	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify: White	
Ŏ	2 ho	Completed by	15. Decedent's Ed (Specify only highest gra		ecedent's Usual Occupation Give kind of work done during most of w	orkina	16b. Kind of Business	/Industry
3	thin 7	ple	Elementary/Secondary (0-12)	College (1-4or 5+)	ife. DO NOT use retired)	g	Religious	Community
7	or th	50		College 5+ N	Nursing			of Charity
p	tal Hy doth	Be	17. Father's Name (First, Middle, Last)				, Maiden Sumame)	
<u>X</u>	should to	ည	John Charles C			Tane Rahl		
a	C1 (0) = 0		19a. Informant's Name/Relationship (7	m Cumorri or	Mailing Address (Street and Number or I			
2	and sealth m 27		<u>Sister Camilla H</u>	arant 33	3 S. Seton Avenue,	Emmitsb Date	20c. Location - City of	
Ore	of H if ite		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □	Removal from State	Disposition (Name of Screppinon Spr other place)	/27/2008	Emmitsbu	
<u>=</u>	Pag ment ant: jury	١.,	4 □ Donation 5 □ Other (Specify		tar nouse			
Baltimore, Maryland 21215-0036	permit. Pages 1 and Department of Health Important: if item 27 any injury or other t		21. Signature of Funeral Savice Licen	Sulmo	22. Name and Address of Facility I	Myers-Dur mmitsburg	boraw Fune: , MD 21727	ral Home
		V	23a. Part). Enter the disease, or comp	plications that caused the death. Do no	t enter the mode of dying, such as card	ac or respiratory a	rrest,	Approximate Interval Between
	Dhusisian		shock, or heart failure. List only in Immediate Cause (Final	one cause on each line.	Cardin	att		Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a consequence of	au myo	parry		2 years
	Examiner			atherisalo	exten Courtin	marila	Disen	20-460-
		e	Sequentially list conditions. if any, leading to immediate	b.  Due to (or as a consequence of		700000	70 32	
	d ansit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events	^				Part .
o Î	be executician and burial-tran	Exa	resulting in death) Last	Due to (or as a consequence of	):			
8760,	ate be executed obysician and the burial-transit	dicai		. d				
9	death certificate e attending physi ed for use as the	0	IF FEMALE:					
Вох	eath certific attending pl	an/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death	3 □Ectopic pregnancy		23d. Date of de Month	elivery Day Year
E	it the dea by the at tached fo	Physician/M	1 ☐ Yes 2 No 9 ☐ Unknown	4□Pregnant at time of death 9□ Unknown	5 Other (specify)			,
P.(	hat thid by			ontributing to death but not resulting in t	the underlying cause given in Part I.	23e. Did 1	tobacco use contribute t	to the cause of death?
Vital Records,	The law requires that ate has been signed b page 2 should be deta	d b	Rend	Failure	, <b>,,</b>	10	Yes 2.00 3□F	robably 4 Unknown
0.0	w requir been si should	Completed				24a. Was	24b Ware 2	utopsy findings available
3ec	elaw hasl je 2 s	ם				auto		completion of cause of
E						1 ☐ Yes	2 No 1 □ Ye	
Z:	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:	Othon	Death Check only		10.
ot	Phys this ral di	٤.	1 Yes 2 No	28a. Date of Injury 28b. Tir	satient 3 DOA 4 DINUTSING		how injury occurred	ecify)
G	ding I h. After funer	ë	1 Natural 5 Pending	(Month, Day Year) Inj	ury Work? ( M 1 ☐ Yes 2 ☐ No			
S	or Attending after death. Director: Afte in by the fune	fica	3 ☐ Suicide 6 ☐ Could not b	1			Street and Number or F	Rural Route Number,
Division	af or Attend s after death f Director: , d in by the f	Certification:	4 Homicide determined	building, etc. (Specify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	City or To	wn, State)	
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Medical (	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exar	hysician: To the best of my knowledge, niner: On the basis of examination and and manner stated.	death occurred at the time, date and pla for investigation, in my opinion, death oc	ace, and due to the courred at the time,	cause(s) and manner a date and place, and du	as stated. ue to the cause(s)
	To the within 2 To the comple	Mec	29b. Signature and title of certifier	A A	29c. License number		29d. Date signed (Mor	nth, Day, Year)
			) \ (XX	om Caust	1110 018705		12/23	108
,	WIL		30. Name and address of person who	completed cause of death (Item 23a) (T	Type, Print)	1/2	1 1	11
	-			roll MD 31	0 S, Seton Aug	Emmi	Isburg /V	la 21727
	St Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's Signature	hoard :		•	

Amended Item 26 per Phy. 12/22/2008 Carroll County, wjl Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Day 18 **Physician** 2008 10:50 pM Donna D. Connors /Medical 4c. County of Death 4h City Town or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Westminster Carroll Carroll Hospice Dove House 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Months Days Hours 1 M 2 M July 2 1932 Maine 76 007-32-1388 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County fshow a or 28a-f show be notified at 1 ☐ Yes 2 XNo Director MD Westminster Carroll 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Apt 302 21157 USA permit. Pages 1 and 2 should be filed within 72 hours after death wi Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must b 507 High Acre Dr Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2 ☑ No Specify: Baltimore, Maryland 21215-0036 þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Educator Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George DeCourey Marie Miller 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4117 Bullfrog Road Taneytown, MD 21787 Erin Kelly/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 12/19/2008 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Carroll Cremation, Inc Hampstead, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Princes Afterior Fally Home and Chapel, P.A. Me 412 Washington Road Westminster, MD 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final **Physician** PROGRESSIVE CEREBRAL ISCHEMIA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner YEARS EREBRAL MICR: Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the Hospital or Attending Physician; The law requires that the death certificate be executed burial-trai Due to (or as a consequence of): physician a the burial Division or Vital Records, P.O. Box 68760, by Physician/Medical as attending plant for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) ed by the a 9☐Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 √ es 2 No 3 Probably 4 Unknown CORONARY ATHERO SCLEROTIC Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 No 1□ Yes 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Hospital: 1 ☐ Copation 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 MOther (Specify) Hospice 1 Yes 2 No ပ္ To the Hospital or Attending Phwithin 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral 28b. Time of 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Certification: Injury 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide Detrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item sa) (Type, Print) DO 1663 WJL VINCENT - FIOCES JR 12

State Registrar

31. Date filed (Month, Day, Year) DEC 2 2 2008

EBS 7

32. Rajistrar's Signature

MAIN

State of Maryland / Department of Health and Mental Hygien 2008 43018 1 - State AMEND#29d, perMD, 12/26/08, DPS, McCo Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Yeer **Physician** 9:10am Dec 19,2008 Marguerite Carlson Crimmins /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth Examiner Collington Retirement Home Mitchellville Prince Georges 5. Social Security Number 470–16–7162 If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth May 13, 1918 6. Sex 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign **Funeral** 1 ☐ M 2 🖾 F Months Missesota 90 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits in then "natural", or Items 23s or 28s-f show the Medical Extrational by multipled at Director MD Prince Georges TV Yes 2 □ No Mitchellville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10450 Lottsford Rd 20721 United States filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: Specify: White þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygiei Importent: If item 27 is marked other 11 any injury or other traumatic avant, ITIs ONCE. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Daniel Theodore Carlson Ruth Elina Kalberg 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10437 Waterfowl Terrace, Columbia, MD 21044 John Hugh Crimmins, JR/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Eremation 3 ☐ Removal from State 12/24/2008 4 ☐ Donation 5 ☐ Other (Specify) nal Crematory | 12,27,2000 Falls Church VA
22. Name and Address of Facility Joseph Gawler 5 5018, INC National Crematory 21. Signature of Funeral Service Licensee LAVE D 5130 Wisconsin Ave, N.W. Washington DC 20016 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of aying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a/dlom /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to to, as a consequence of. Examiner burial-transit The law requires that the death certificate be executed and Due to (or as a consequence of): Box 68760. attending physicien Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 Other (specify) P.O. 1 the a detached 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 99 1 🗆 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an was a...
autopsy
performed?
Yes 2 No certificate has 1 ☐ Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: 1 | Inpatrent 1 ☐ Yes 2 No Other: ۵ 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ☐ FR/Outpatient 3□ DOA this funeral c 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Certification: 5 Pending 1 XNatural within 24 hours after death. To the Funeral Director: A investigation 1 □ Yes 2 □ No 2 Accident 6 Could not be determined 3 Suicide Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide To the Hospitel 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title(of sertifier 29c. License number 10 e of person who completed cause of death (Item 23a) (Type, Print) Mirchally le avekoh 31. Date filed (Month) 32. Registrar's Signature State 6 2008 Registrar

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Raymond Covington Collins 10:03 am 23, 2008 December 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Date of Birth (Month, Day, Year) Months 1 M 2 □ F Yrs 354-16-5744 80 29. 1928 Illinois Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 TX No Maryland Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 1220 East West Highway, Apt. 1405 20910 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc 1XXes 2 No If Yes, Give Year or Dates: 1951-53 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify:

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

22. Name and Address of Facility

Musician

20b. Place of Disposition (Name of cemetery, crematory or other place)

23a. Part 1. Anter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

VETNEX-OSECEROTIE

PERIEWSIVE

Due to (or es a consequence of):

Due to (or as a consequence of):

Due to (or es e consequence of):

SMIC

Metropolitan Crematory

Black

Approximate Interval Between Onset and Death

**Entertainment** 

16b. Kind of Business/Industry

20c. Location - City or Town, State

Alexandria, Virginia

18. Mother's Name (First, Middle, Maiden Surname)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20910

1220 East West Highway, Apt. 1405, Silver Spring, M

Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring MD 20901

27,

Irma Lewis

Date

2008

Dec.

**Physician** /Medical Examiner 1 - For State Registrar

10a State

3 Widowed 4 Divorced

Elementary/Secondary (0-12)

Unknown

20a. Method of Disposition

Immediate Cause (Final

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

disease or condition resulting in death)

IF FEMALE:

17. Father's Name (First, Middle, Last)

19a. Informant's Name/Relationship (Type. Print) Catherine C. Collins/Wife

4 Donation 5 Dother (Specify)

21. Signature of Funeral Service Licensee

15. Decedent's Education (Specify only highest grade completed)

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

College (1-4or 5+)

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

ò

items 23a

ò

"natural",

permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any Injury or other traumatic event, tre Medical once.

Examiner must be notified at

Director

Funeral

þ

Completed

Be

္ရ

Examine

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

an/Medical

Hospital or Attending Physician: The law requires that the death certificate be executed Funcs after death.

Funeral birector: After this certificate has been signed by the attending physician and stely filled in by the functed director, page 2 should be detached for use as the burial-transit 24 hours a e Funerai [ letely filled within 2 To the

Division of Vital Records, P.O. Box 68760,

Physician/N	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy  1	23d. Date of delivery Month Day Year							
Completed by Pl	Part II. Other significant conditions of	co use contribute to the cause of death?  2 No 3 Probably 4 Unknown								
		24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No								
Be	25. Was case referred to medical examiner?	Hospital:	26. Place of Dea	ath (Check only one)						
2	1⊿Yes 2□No	1 Inpatient 2 EH/Outpatient 3	lome 5 Residence							
ation:	27. Man of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation		28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	jury occurred					
Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, fac building, etc. (Specify)	tory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)					
Medical (	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
W	29b. Signature and tile of certifier  29c. License number  29d. Date signed (Month, Day, Year)  12/23/08									
	30. Name and address of person who Don Michael Cole	completed cause of death (Item 23a) (Type, Print) eman, MD 20010 Centur	ry Blvd. #200,	Germantow	n, MD 20874					
State istrar	31. Date filed (Month Day, Year) 6	2008 32. Registrar's Signature								
/ 1/2001		0710111								

2

Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examitrat must be notified at once.
200	Physician /Medical Examiner
- Jane	Examiner
Division of Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Funeral Director

	1 - State of Maryland / Department	rtment of Health and N rificate of Death	Mental Hygiene	)				
Physician	1. Decedent's Name <i>(First, Middle, Last)</i> Catherine Tychanski Collins		2. Date of Death Month Day Dec. 17, 2008	3. Time of Death 3:50 p M				
/Medical Examiner	4a. Facility Name (If not institution, give street and number) 4806 Topping Road	4b. City, Town, or Location of Death  Rockville	4c. County					
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 M 2 1 F 83 Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Year) Jan. 7, 1925	9. Birthplace (State or Foreign Country) Wisconsin				
f show ind at tor	Usual Residence of Decedent  10a. State  10b. County  10c. City, Town or Loc.  Maryland  Montgomery  Rockvil			10d. Inside City Limits 1 ☐ Yes 2 🕱 No				
be notified be notified Director	10e. Street and Number	10f. Zip Code 10g. Citizen of What Country?						
Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ite Medical Examirur must be notified at once.  To Be Completed by Funeral Director	Armed Forces? If	as Decedent of Hispanic Origin? (Sp Yes, specify Cuban, Mexican, Puerto □Yes 2¶No Specify:		e - American Indian, k, White, etc. White				
ygiene. er than "natur t, the Medical E Completed	(Specify only highest grade completed) (Give k Elementary/Secondary (0-12) College (1-4or 5+)	ent's Usual Occupation ind of work done during most of work O NOT use retired) .nown	ing 16b. Kind of Bu	·				
Mental Hy arked othe atlc event, To Be C	17. Father's Name (First, Middle, Last)  John Tychanski, Sr.	18. Mother's Nam Mary Wi	e (First, Middle, Maiden Surnam tczak	e)				
alth and M 27 is mar r traumat	19a. Informant's Name/Relationship (Type. Print) Christine M. Collins/Daughter  19b. Mailing	Address (Street and Number or Run 324 Olney Mill Ro	al Route Number, City or Town, ad, Olney, MD 2	State, Zip Code) 20832				
nent of Hee int: If item iry or othe	20a. Method of Disposition  1	leaven Cemeterv	ec. 23	City or Town, State				
Departr Importa any Inju		Name and Address of Facility Cancis J. Collins OO University Blv	Funeral Home	Inc.				
ohysician and the burial-transit the burial-transit dical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not ente shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Coronary Artery Disease of Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):		or respiratory arrest,	Approximate Interval Between Onset and Death 7 years				
within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicia completely filled in by the funeral director, page 2 should be detached for use as the burn Medical Certification: To Be Completed by Physician/Medical		Ectopic pregnancy Other (specify)	23d. Dat Moi	e of delivery nth Day Year				
an signed build be deta	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Urinary Tract Infection  23e. Did tobacco use contribute to the conditions contribute to the conditions are contributed to the conditions are conditions are contributed to the conditions are conditionally are conditions.							
icate has been single page 2 should			autopsy performed? d	Nere autopsy findings available prior to completion of cause of leath?				
his certiful director	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	Other:	h <i>(Check only one)</i> ome 5 <b>⊈</b> Residence 6 □ Othe	er (Specify)				
rs after death. al Director: After the dea in by the funeral Certification: T	27. Manner of Death  1 X Natural 2	28c. Injury at Work? M 1 □ Yes 2 □ No	28d. Describe how injury occurre	Now injury occurred  Street and Number or Rural Route Number,				
ithin 24 hours the Funeral ompletely filler Medical C	29a. Certifier (Chack only one)  Certifying Physician: To the best of my knowledge, death one)  Medical Examiner: On the basis of examination and/or invalid manner stated.	occurred at the time, date and place, estigation, in my opinion, death occur	and due to the cause(s) and ma red at the time, date and place, a	anner as stated. and due to the cause(s)				
To th comp	29b. Signature and title of certifier	29c. License number	29d. Date signed December	(Month, Day, Year)				
	_	Philip Drive, Ol	ney, MD 20832					
State Registrar	31. Date filed (Month, Day, Year) DEC 2 4 2008  32 Segistrar's Signature	WE .						

8

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) December 21, 2008 **Physician** 10:10A.M Pauline T. Cooke /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Takoma Park Washington Adventist Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Aug. 19,1921 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months Days Min. Hours West Virginia 1 □ M 2√2 F 87 234-28-8959 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2X No Prince George's Beltsville Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20705 United States 13023 Bellevue Street by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 2 **1**No 1 Never Married 2 Married 1 ☐ Yes 2 【XNo Specify. White Specify: 3 Widowed 4 □ Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Federal Government Administrative Assistant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (unk) Sylvia Clayton Tincher 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6914 Pendulum Lane Columbia, Maryland 21044 Kenneth L. Cooke -son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State Metropolitan Crematory 12/17/2008 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Bonald V. Borgwardt Funeral Home, PA exold 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Severe Ischemic Cardiomyopathy disease or condition resulting in death) Due to (or as a consequence of) Hypoxia Sequentially list conditions fo for an a nonnequence off cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. if yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 Yes 2 No Month Year Dav 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Hypertension; Chronic Kidney Disease 1 Yes 2 No 3 Probably Wunknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2X No 24a. Was an 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 KER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Injury

Physician /Medical Examiner

**Funeral** 

Director

show

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryls Department of Health and Mental Hyglene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examiner must be notifiled at once.

3altimore, Maryland 21215-0036

Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit signed by the a Be Completed by Certification: To

Division or Vital Records, P.O. Box 68760,

28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

6 Could not be determined

T. MAITIC M.D.

and manner stated.

29c. License number D59121

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

December 22, 2008

State Registrar

Medical

31. Date filed (Month, Day, Year)

2 Accident

4 Homicide

(Check only one)

3 Suicide

29a. Certifier

2 4 2008 DEC



State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician**  $\underline{\underline{A}}^{\mathsf{M}}$ 4:25 18, 2008 December Robert Marshall Casey /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Silver Spring Montgomery Holy Cross Hospital
5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) **Funeral** Months Davs Hours 1 □**X**M 2 □ F Yrs. Nov 30, 1922 Massachusetts 86 Director 012-14-6378 Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, Ins Modeal Examiner must be notified at 1 ☐ Yes 2X No Funeral Director Maryland Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 20906 3100 N. Leisure World Blvd, Apt. 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 TYes 2 No If Yes, Give Year or Dates: WWII 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 XNo Completed by White 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Navy 5+ is 1 and 2 should be filed with Health and Mental Hygien tem 27 is marked other th Attorney 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Deehan Robert Andrew Casey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 20904 19a, Informant's Name/Relationship (Type, Print) 3100 N. Leisure World Blvd, Apt. 718 Silver Spring Eleanor Casey/Wife other Department of Heal Important: If item 2 any injury or other once. Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington National Cem Feb 19, 2009 Arlington, VA 22. Name and Address of Facility. Hines-Rinaldi Funeral Home 21. Signature of Funeral Service Licensee Myslin T. What 11800 New Hampshire Ave, Silver Spring, MD 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Subarachnoid Hemorrhage disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Advanced Dementia Sequentially list conditions Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last be executed burial-transit <u>Coagulopa</u>thy and Due to (or as a consequence of) physician Physician/Medical the as attending IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year for in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) o signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 ☐ Yes 2 🖾 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 TNo 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) Hospital or Attending Pl 24 hours after death. Funeral Director; After the 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 1X Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical npletely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. To the within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0065953 December 18, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Rd, Silver Spring, MD 20910 MD Dr. Adaku Onukogu, 31. Date filed (Month, Day, Year) 24 DEC Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2008 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month Pauline Chapman 30 08 2104 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death <u>ALLEGANY</u> WMHS BRADDOCK CAMPUS CUMBERLAND Date of Birth Month, Day Ye Dec 23, 9. Birthplace (State or Foreign Country MD 5. Social Security Number 7. Age (In yrs. last birthday, 1 □ M 2 □ F 192-10-5203 93 Usual Residence of Decedent 10c. City, Town or Locetion 10d. Inside City Limits 10a. State 10b. Count MD Allegany Cumberland 1 □XYes 2 □ No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21502 1000 Kent Avenue USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 □ No Specify Specify: white 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) bookkeeper Schwab Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Daisy B. Lewis Wagner Claude W. Wagner, Sr. 19a. Informant's Name/Relationship (Type. Print) Carrie Platt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12400 Crossroad Court Cumberland MD 21502 sister 20b. Place of Disposition (Name of cemetery, crematory or other place) Restlawn Memorial Gardens 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 1/5/2009 LaVale MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Servi Licens 22. Name and Address of Furtheral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Rena Acule Due to (or es a consequence of): ehydratio Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) rinary Due to (or as a co IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant et time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 ☐ Unknown 24a Was an 24h Were autonsy findings available

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, burial-tra attending physician for use as the burial ed by the a signed by t has

**Physician** 

/Medical

Examiner Completed Certification: To within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral. Medical

**Physician** 

/Medical

Examiner

Director

Funeral

Completed by

Be

ည

Examiner

Physician/Medical

2

Be

29b. Signature and little of certifier

**Funeral** 

**Director** 

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ratural", or items 23a or 28a-f show any Injury or other traumatic event, it is Medical Event instrumed be putilised anonge.

Baltimore, Maryland 21215-0036

										autopsy performed? 1 ☐ Yes 2 ☑ No	prior to d death? 1 □ Yes	completion of cause of 2 ☑No
25. Was case refer	red to medical		/				26.	Place of Dea	th (C	Check only one)		
examiner? 1 ☐ Yes 2 ☑ No		Hospi	tal: 1 Inpatient 2 □	] ER/Outpatient	3 □	DOA	Other: 4	☐ Nursing H	lome	5 Residence 6	Other (Spec	cify)
27. Manner of Deat 1 ✓ Natural 2 ☐ Accident	5 ☐ Pending investigation		Ba. Date of Injury (Month, Day, Year)	28b. Time of Injury	М	28c.	Injury at Work? 1 □ Yes	2 🗆 No	280	I. Describe how injury o	ccurred	
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined		Be. Place of Injury - At h building, etc. (Speci	nome, farm, stre	et, fact	ory, of	ffice		28f.	Location (Street and N City or Town, State)	lumber or Ru	ral Route Number,
29a. Certifier (Check only one)		niner:								d due to the cause(s) at at the time, date and pl		

10

State

29d. Date signed (Month, Day, Year)

Hecember 31, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

everli alk Maryland 31. Date filed (Month, Day, Year) 32. Registrar's Signatur JAN 1 2 2009

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year 1055 AM **Physician** Aleyia Dyson Heaven 2008 12 5 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** La Plata Civista medical Center Charles Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 12 25 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Year) Min. Days 1 □ M 2 XF 2008 Maryland Director NONE Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examinar must be rediffer an once. 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State 1 Yes 2 No MD. CHARLES LA PLATA Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20646 U.S.A. 6101 ROSE HILL ROAD Funeral Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married 1 □Yes 2 No Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) INFANT N/A17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Andrea Sellers Sr Price David Garnell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) ANDREA DYSON-MOTHER 6101 ROSE HILL RD. LA PLATA, MD. 20646 20b. Place of Disposition (Name of cemetery, crematory or other place) ST.JOSEPH'S CEM. 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ▼Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 12-30-08 POMFRET, MD. 22. Name and Address of Facility 21. Signature of Juneral Service Licensee M00479 RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MD. 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final EXTREME PREMATURITY **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, in the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 No 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 🔀 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

Hospitel or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and Division of Vital Records, P.O. Box 68760, completely filled in by the within 2

Baltimore, Maryland 21215-0036

State Registrar

31. Date filed (Month, Day; Year)

(Check only one)

29b. Signature and title of certifier

SAYEED FAROOQUI, MD 701 E CHARLES ST LA PLATA MD 20646

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

#82. Registrar's Signature

29c. License number

D56395

29d. Date signed (Month, Day, Year)

08

3-09458		Please Type	or Print in Blac	ck Inde	lible Ink.	Ensure	All Copie	es Are Leç	gible.		
ichard Craig Da		Stat 1- For State Registrar	e of Maryland / [		nent of Hea cate of Dea		Mental H		g. No.	300	4302
Physicia ledical Exami	ın/	Decedent's Name (First, Middle, L Richard Craig						2. Date of Deat Month December			Time of Death 0855 hrs
		4a. Facility Name (if not institution, 4405 Black Rock Road	give street and number)			, Town, or Li erco	ocation of Death	n	4c. County of Baltimore		/
Funeral Director		540 21 2944	Sex 7. Age (I	In yrs. last bi		ths Days	If Under 24Hrs Hours Mir		/1921	<ol> <li>Birthple</li> <li>Foreign Countril</li> </ol>	MA
rd how any Ee.	7	Usual Residence of Decedent  10a. State 10b. County  Maryland Carrol	N N	oc. City, Tow Hamps	n or Location tead						d. Inside City Limits  Yes 2 X No
the Maryland a or 28a-f show	Director	10e. Street and Number 4632 Lower Bec	kleysville R	oad		Tip Code 1074			og Citizen of Wha nited St		?
ifter death with the Maryland 1", or items 23a or 28a-f sho per must be notified at once.	by Funeral	11. Marital Status 1 Never Married 2 Marr 3 Widowed 4 Divord	12. Was Decedent Ev Armed Forces? 1 Yes 2 X ced If Yes, Deceded to the control of	ver in U.S.		cify Cuban,	Mexican, Puerto	Specify Yes or No o Rican, etc.)	White,		i Indian, Black,
Baltimore, MD 21215-0036 pernit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If iten 27 is marked other than "natural", or items 23a or 28a-f she injury or other tranmatic event, the Medical Examiner must be notified at once	Completed b	15. Decedent's Education (Specify Elementary/Secondary (0-12) 12	only highest grade complete (1-4 or 5+)		Decedent's Usu during most of the carpente	vorking life. I			constru		
	Be Col	17. Father's Name (First, Middle, La Robert C. Danie		· · · · · ·			Sara K	athryn G			
MD 21 d 2 should th and Me n 27 is ma	2	19a. Informant's Name/Relationship Linda R. Daniel			4632 Lov	er Re	ckleysv	Rural Route Nun ille Roa	nber, City or Town	, State, Zi stead	p Code) , MID 21074
Baltimore, permit. Pages I and Department of Heal Important: If iten		20a. Method of Disposition  1 XBurial 2 Cremation  4 Donation 5 Other Spec		crem	e of Disposition (fatory or other place of Hill (	ce)	Dec	Date 2. 27, 2008	Brookly	•	<sub>wn, State</sub> aryland
Balt permit Depart Impor injury		21. Signature of Funeral Service Li	unn	M0107	2 934 9		Main St	reet Ha		, Mar	yland21074
Physician /Medical xaminer		23a. Part I. Enter the disease, or co- failure. List only one cause or Immediate Cause (Final disease or condition resulting in death)			not enter the mod	e of dying, s	such as cardiac	or respiratory arr	est, shock, or hea		Approximate Interval Between Onset and Death
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	b	uence of):			-		-		
executed an and al - transit	I Examin	(Disease or injury that mitiated events resulting in death) Last	Due to (or as a consequent)	uence of):				_			
	Medica	UNPENDED  IF FEMALE:	X AMENDED Ite			12/22	/2008 0	arroll (	Co., wj1	dolivor	
Box 68760, e death certificate be execut the attending physician and ed for use as the burial - tra		23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	1 Live birth 4 Pregnant at tir		2 Fetal dea		Ectopic pregr	nancy	Month	Day	Year
s, P.O. B nires that the d signed by the	ā	Part II. Other significant condition	ns contributing to death b	out not result	ing in the underly	ing cause gi	ven in Part I.		obacco use contril		e cause of death?
cords aw requas been	Completed							24a. Was autor perfo 1 🗸 Yes	p p rmed? d		osy findings available apletion of cause of
Vital Rechysician: The lathic certificate ladirector, page	Be	25. Was case referred to medical examiner?  1 ✓ Yes 2 No	Hospital: 1 Inpatient	2 ER/	Outpatient 3		of Death (Check Other: Nurs	k only one) ing Home 5	Residence 6	Other: S	cene
on of vending Physath.  or: After the funeral	tion: To	27. Manner of Death  1 Natural 5 Pendin		r) 28t Ur	o. Time of Injury	1	y at Work? es 2 V No		how injury occurre in auto to aut		on
Division  To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	2  Accident Investig 3  Sulcide 6  Could determ	not be 28e. Place of Injur			ory, office bu	uilding, etc.		Street and Numbe State) lock Road, Upp		Route Number, City
To the Hosp within 24 ho To the Fun completely	Medical C		sician: To the best of my kiner:On the basis of examinand manner stated.								
- s - o	žΙ	29b. Signature and title of certifier				29c. License	number		29d. Date signe	d (Month	, Day, Year)

1 Yes 2 No 9 Unknown	9 Unknown	J Other (S)						
Part II. Other significant conditions co	ontributing to death but not res	23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Unknown						
				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1  Yes 2 No			
25. Was case referred to medical	26.Place of Death (Check only one)							
examiner? 1 ✓ Yes 2 No	pital: 1 Inpatient 2 E	ER/Outpatient 3	DOA Other Nurs	sing Home 5 Residence	ce 6 🗸 Other: Scene			
27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation	(Month Day Year)	28b. Time of Injury <b>Unknow</b> n	28c. Injury at Work?  1 Yes 2 No	28d. Describe how injury Passenger in auto				
3 Suicide 6 Could not be determined	28e. Place of Injury - At hor (Specify) Major Road		28f. Location (Street and Number or Rural Route Number, City or Town, State) 4405 Black Rock Road, Upperco, MD					
( on only	: To the best of my knowledge n the basis of examination and							

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)
DEC 2

Pamela E. Southall, MD

30. Name and address of person who completed cause of death (Item 23a)

ORIGINAL

Assistant Medical Examiner

32. Registrar's Signature

WJL

6

29d. Date signed (Month, Day, Year)

December 17, 2008

		For State	State of Mary				ınd Ment			n o	43026	
		Registrative UFIZUO, pentil, 12/20/08, DES, NO.						Reg. No. 2 0 0 8 4 3 0 2 6				
Physicia		1. Decedent's Name (First, Middle, Last)  John F. Dowd						2. Date of Death Month Day Year December 19, 2008 4:05 p M				
/Medic		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Local					n of Death 4c. County of Death					
	3148 Gracefield Road, #217				Silver Spring  If Under 1 Year   If Under 24 Hrs.   8 Day			Prince George's  e of Birth 9. Birthplace (State or Foreign				
Funeral Director		5. Social Security Number 091-18-6759	M O C C	yrs. last birth 4 Y	Months Days	Hours	Min. (N	ate of Birth fonth, Day, 1 ne 22,	Year) 1924	Country New	York	
ъ		Usual Residence of Decedent		0: 7	1					100	d. Inside City Limits	
arylar show	'n	10a. State 10b. County		c. City, Town						100	1 □Yes 2 📉 io	
the M	Director	Maryland Princ  10e. Street and Number	e George's	Sil	ver Spring  10f. Zip Code			100	g. Citizen of W	/hat Countr	y?	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentall Hydiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is in it is included at once.		3148 Gracefield Road, #217			20904	20904				USA		
	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?			13. Was Decedent of Hispanic Origin? (Speci- If Yes, specify Cuban, Mexican, Puerto Ric			es or No- , etc.)		14. Race - American Indian, Black, White, etc.		
s after	by Fu	1 ☐ Never Married 2 🔀 Marrie 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give		-84 1 □Yes 2 🛣 No		Specify:		Specify: White			
2 hour		15. Decedent's	Education	ecedent's Usual Occupation			16		b. Kind of Business/Industry			
thin 72 an "na Media	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+) 5+			(Give kind of work done during most of working life. DO NOT use retired)			U.S. Navy				
ed wit hygien her th					Captain	19 Mothor	r's Name (Fire	t Middle Ma				
intal H ed oth	Be	17. Father's Name (First, Middle, Last)  Francis Dowd				18. Mother's Name (First, Middle, Ma. Sarah Brennan				iden Surname)		
should mark mark	2	19a. Informant's Name/Relationsh	ip (Type. Print)	19b.	Mailing Address (Street	I t and Numbe	er or Rural Rou	ıte Number,	City or Town,	State, Zip (	Code)	
und 2 alth a alth a 27 is		Alberta A. Dowd	/Wife	31	48 Gracefic	eld Ro	ad, #2	17, Si	lver S	pring	, MD 20904	
es 1 a of He if item		20a. Method of Disposition 1   Burial 2 □ Cremation	1	cemetery	Disposition (Name of crematory or other pla	ice)	Date <b>Feb</b> .		Oc. Location -	City or Tow	n, State	
Pag tment tant:		4 ☐ Donation 5 ☐ Other (Sp	ecify)	Arling Ce	ton Nation	;ZU	)09 <del>200</del>	8-   A			irginia	
Dar Permit Depar Impor any in		21. Signature of Funeral Service L	icensee		Francis						WD 00001	
		23a. Part 1. Enter the disease, or o	complications that caused the	death. Do no	500 Univer						Approximate Interval Between	
Physician	O. N	shock, or heart failure. List of Immediate Cause (Final disease or condition	100-100	. Henr	t Eniluma					rs.	Onset and Death	
/Medical		resulting in death)	Due to (or as a co		t Failure							
Examiner	_	Sequentially list conditions,	b. Coronary  Due to lor as a co	Diseas	e							
rted nsit	nine	cause. Enter Underlying Cause (Disease or injury that initiated events	Due to jor as a co	insequence o	j.							
executing and ial-tra	Due to [or as a consequence of]:  Cause. Enter Underlying Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):											
icate be executed physician and street transit street burial-transit	dical		d									
ertifica	Med	IF FEMALE:	23c. If yes, outcome of p	regnancy					004.5-			
eath certifii attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 4 Pregnant at tim	☐ Fetal death 3 ☐ Ectopic pregnancy						23d. Date of delivery Month Day Year		
the d	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown										
gned	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death?				
law requires t as been signe 2 should be o	ted	Ventricular Tachycardia, Hypertension					- 1	1 L Yes	2 ☐ No 3 ☐ Probably 4x Unknown			
24a. Was an autopsy performed?  1   Vest 2   No.								,	24b. Were autopsy findings available prior to completion of cause of death?			
VILAI F ician; Th certificate ector, pag	e Co	25. Was case referred to medical				OC Diago	of Death (Ch	1 □Yes 2	No N	1 □Yes 2	2 □ No	
ysicia ysicia s cert	To Be	examiner?  1 Yes 2 No	Hospital: 1 ☐ Inpatient	2   ER/Out	patient 3 DOA Ot	hor				ner (Specify	)	
Attending Phy ar death. ector: After this by the funeral of	T:UC											
tendii leath. Ior: A the fu	27. Manner of Death 1 Tanhatural 2 Accident 3 Suicide 4 Homicide 2 Accident 4 Homicide 2 Accident 5 Pending investigation 2 Ba. Date of Injury (Month, Day, Year) 28b. Inme of Injury at Work? 1 Tanhatural 2 Page. Injury at Work? 1 Tanhatural 2 Page. Place of Injury - At home, farm, street, factory, office 2 Page. Place of Injury - At home, farm, street, factory, office 2 Page. Place of Injury - At home, farm, street, factory, office 2 Page. Place of Injury - At home, farm, street, factory, office 2 Page. Place of Injury - At home, farm, street, factory, office 2 Page. Injury at Work? 2 Page. Place of Injury - At home, farm, street, factory, office 2 Page. Place of Injury - At home, farm, street, factory, office 2 Page. Place of Injury - At home, farm, street, factory, office 2 Page. Place of Injury - At home, farm, street, factory, office								Davida Mumbas			
or At or At after d Direct in by	ərtifi	4 Homicide determi		- At home, far Specify)	m, street, factory, office		281. L	Dity or Town,	State)	er or Hurai	Houte Number,	
spital hours neral y filled										ated.		
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check only 2 Medical I	Examiner: On the basis of ex and manner stated				am occurred at					
vith To t com	Σ	29b. Signature and title of certifier	Alminite	POS	29c. Licen	nse number	01101		d. Date signe		e23	
U			The second		Tuno Brieth	DOO	1848	1 1	2-2	2-0	2	
		30. Name and address of person Bruce Zinsmei	ster, MD 88	30 Came	eron Street	, #60]	l, Silv	er Spi	ring, N	1D 209	10	
Sta		31. Date filed (Month, Day, Year)	3 Registrar's	Signature	heats)							
Regist	ar	DEC 24	2008	J. A.	MARKET STATES							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 22 **Physician** 5:20 A M Docember 2008 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 710 O'Brecht MD In Kes 4/10 arroll Date of Birth (Month, Day, Year) 6. Sex If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days **₩** M 2□F Yrs 85 Puerto Rico Director Usual Besidence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits show permit. Pages 1 and 2 should be flied within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f shov any Injury or other traumatic event, the Medical Examiner must be notified at 1 X Yes 2 No Director Maryland Carroll Sykesville 10e. Street and Number 10f Zin Code 10g, Citizen of What Country? 21784 U.S.A. 710 O'Brecht Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 ☐ Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☑ Yes 2 ☐ No Specify: Puerto Rican Specify: White ģ 3 ☐ Widowed 4 🖾 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Lawyer Law 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Abrahan Diaz-Viena Maria Luisa Gonzalez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hilda Diaz-Soltero / Daughter 1324 30th St., N.W. Washington, DC 20007 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan
Crematory 20a. Method of Disposition Date 20c. Location - City or Town, State 22, 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Dec. 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia 2008 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service Licensee 2222 Wisconsin Ave., N.W. Wash., D.C. 20007 Remen 23a. Part 1 Priter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 12heimer diseuse sears /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the attending ph IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown signed t I be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 2 No 1 □ Yes 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy type II performe To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) r 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No hours after death. uneral Director: A 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2. 29b. Signature and title of oertifier 29c. License number 29d. Date signed (Month, Day, Year) >34849

State Registrar 1645 Liber

Registrar's Signature

Road Eldersburg MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jan

2008

24

31. Date filed (Month, Day, Year)

DEC

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 For State RegistraMFND#9+12per\*INF12/29/08, EMV, McCo Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** Eddie Lee Daniel 1:32 p<sup>M</sup> December 21, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 9302 East Parkhill Drive Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign County) ississippi
 Michigan 5. Social Security Number 7. Age (In yrs. last birthday, Date of Birth (Month, Day, Year) Funeral Days Hours Min Months 1 🛣 M 2 🗆 F 91 225-50-9192 19, 1917 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 X Yes 2 □ No Director Maryland Montgomery Bethesda 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number death with 20814 9302 East Parkhill Drive USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black. White, etc. 2 No. 36-1936-1 Pages 1 and 2 should be filed within 72 hours after of the atth and Mental Hygiene. 1 X Yes 2 N if Yes, Give Year or Dates: 1 Never Married 2K Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify Specify: White 2 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) th and Mental Hyglene.
7 Is marked other than "natur traumatic event, the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Military Captain U.S. Marine Corp 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thomas Leroy Daniel Amanda Alexander ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Heath ar Important: If item 27 Is any injury or other trau once. Florence L. Daniel/Wife 9302 East Parkhill Drive, Bethesda, MD 20814 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date ₩ Burial 2 Cremation 3 Removal from State 30, Dec. Arlington National 4 ☐ Donation 5 ☐ Other (Specify) 2008 Cemetary 2008 Arlington.
22 Name an Address of Facility
Francis J. Collins Funeral Home Inc. Arlington, Virginia 21. Signature of Funeral Service Licenses 500 University Blvd. W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Metastatic Colon Cancer years disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Heart Failure Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Chronic Renal Insufficiency Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐Yes 2X No 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5XXResidence 6 Other (Specify) Hospital: 1 Tes 2X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) funeral 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After 1X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after deatl

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier. 290. License number ျှ

State Registrar

31. Date filed (Month, Day, Year) 2 4 2008 DEC



VA0102202271

December 23, 2008

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Reg. No. 2008 43029 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** nineas 100 prague /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Howard Howard County General Hospital Columbia If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min. Months Days Hours **XX**M 2□ F 8-13-1926 VA 82 Director 242-44-2871 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 200 No Director Ellicott City MD Howard 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō Pages 1 and 2 should be filed within 72 hours after death with 21043 "natural", or items 23a 2617 Orchard Ave. USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? ★RYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married XX Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 5+ Attorney Law 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Samuel Dixon Lucile French ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2617 Orchard Ave., Ellicott City, MD 21043 Carole Dixon / Wife of Health 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition Department of Important: If it any injury or concept. 1 ■ Burial 2 Cremation 3 Removal from State 5 ☐ Other (Specify) Good Shepherd Cem. 12-31-2008 Ellicott City, MD 4 Donation of Funeral Service Icensee 22. Name and Address of Facility Harry H. Witzke's Family F.H. M01411 du 4112 Old Columbia Pike, Ellicott City, MD 21043 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner month OMMO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events securities to death). Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 □Yes 2 □No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the upderlying cause given in Part I. Division of Vital Records, Completed by 2 🗌 No 3 ☐ Probably 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No onary 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manger of Death 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 No 24 hours after death. investigation 2 Accident filled in by the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. within 24 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JALVATE 20)2 31. Date filed (Month, Day, State 24 Registrar

DHMH 17 Rev 1/2001

Box 68760.

P.O. 1

State of Maryland / Department of Health and Mental Hygier ? 43030 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** December 23, 2008 8:55 A Day David /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1014 Beaglin Park Drive Apt. 104 Wicomico Salisbury 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6-26-1918 Birthptace (State or Foreign Country) 5. Social Security Number **Funeral** Days 1 X M 2 □ F Delaware 214-10-7894 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-1 show traumatic event, the Medical Examiner must be notified at 1X Yes 2 No Directo Salisbury Wicomico 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ö USA or itsme 23a 1014 Beaglin Park Drive, Apt. 104 21804 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene Important: If Item 27 is marked other than "natural", or Item any injury or other traumatic event, the Medical Exemples 900. XYes 2 Yes, Give 2 No 1941-1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White ğ 3 X Widowed 4 ☐ Divorced Year or Dates: 1944 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Public Accountant Accountant 11 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Nellie Horn Mitchell 2 Charles 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 119 E. Isabella Street, Salisbury, MD 21801 Michael H. Day - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Buriat 2 X Cremation 3 ☐ Removat from State 12-24-08 Delmar, Delaware 4 ☐ Donation 5 ☐ Other (Specify) Crematory of Delmarva 22. Name and Address of Facility Bounds Funeral Home 21. Signature of Juneral Service Licensee 705 E Main Street Salisbury, MD 21804 23a. Part1. Enter the disease, or completions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Chupnic /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and s the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Dav Year Month 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1☐ Yes 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 4 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manne of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Injury 1 Natural 5 Pending To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completely filled in by the fun. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2000 52974 address of person who completed cause of death (Item 23a) (Type, Print) 30 Name Divivin Sti, Salubny, and 21804 1346 32. Rastrar's Signature 31. Date filed (Month, Day, Year) State 2008 Registrar DEC 2 9

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Alexander Stowell Elder 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** BelAic Hartord Rehabilitationlenter Belaic Health and If Under 24 Hrs. If Under 1 Year 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday Social Security Number 6. Sex **Funeral** 7/29/1915 1**⅓**M 2□ F Days Hours Mass. 93 088-14-6167 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1¥ Yes 2 □ No Aberdeen MD Harford Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21001 U.S.A. 814 Matthews Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: WWII Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: White \$ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) 12 U.S. Government College (1-4or 5+) Civil Service 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alice Esther Stowell Edward Everett Elder ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is m any injury or other traum once. Aberdeen, Maryland 21001 Barbara L. Elder (Spouse) 814 Matthews Ave. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 1/3/09 Baker Cemetery Aberdeen, Maryland 21. Signature of Fureral Service Licen 22 Name and Address of Facility Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399 23a. Part1. Enter the d-ease. Complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) erebrovascular **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to the classic cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to [or as a consequence of] Physician/Medical Examiner burial-transi Due to (or as a consequence of) the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown cate has been signed by page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform certificate 1□ Yes Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 1 Yes 2 No 3□ DOA 1 Inpatient 2 ER/Outpatient Nursing Home 5 Residence 6 Other (Specify) Certification: To Division or After this funeral 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 5 ☐ Pending investigation Hospital or Attending 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours are: co\_\_\_\_\_
To the Funeral Director: A 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Flural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exposines: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of continer December 31, 2008 D 006398 M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Benjamin Y. Lee. Revolution St. Harrede Graco 31. Date filed (Month, Day, Year) 32. Registrar's Signature

Registrar

State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 30,2008 ROBERT DECEMBER 8:05A PAUL EICHELBERGER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Feb 09. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number Funeral 1 X M 2 □ F Months Maryland 212-14-6234 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any highry or other traumatic event, if a Modical Examiner must be rediffed at once. Brunswick Frederick Maryland 1 Nes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21716 1031 Orndroff Court U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 NYes 2 □ No 1943-14. Race - American Indian. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐Yes 2 No Specify: Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 1944 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Painter County Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Eichelberger Florence Irene Clabuagh Emmett Arville ၉ 19b. Mailing Address (*Street and Number or Rural Route Number, City or Town, State, Zip Code)* 1031 Orndorff Ct, Brunswick, Maryland 21716 19a. Informant's Name/Relationship (Type. Print) Margaret Eichelberger, Wife 20c. Location - City or Town, State 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 □ Cremation 3 □ Removal from State Resthaven Mem Gardens Jan 4, 2009 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) f Euneral Service Liven 22. Name and Address of Facility Reeney & Basford P.A. Funeral Home Signatury 106 East Church St, Frederick, Maryland 21701 M00706 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner 410 Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burlal-transit Exami Division of Vital Records, P.O. Box 68760, 🛜 resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day 5 Other (specify) 1 ☐Yes 2 ☐ No been signed by the s should be detached to 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has t lirector, page 2 s autopsy performed 1 ☐ Yes 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this nours efter death.

neral Director: After this

filled in by the funeral d 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours e

To the Funeral I

completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D35106 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Myung Hee Nam, M.D., 400 West Seventh Street, Frederick, Maryland 21701

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

JAN 1 2 2009

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND J.T.E.M. 2015, per FH G887, 1/12/09 WS.

Amend #23a per Phys.; 6887 1/2/1/09 Wental Hygiene

Certificate of Death

Reg. No. 2008 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician December 19, 2008 Caroline A. Eustace 5:00 A.M. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford Aberdeen 312 Heron St. 8. Date of Birth (Month, Day, Year)
Mar. 12, 1 If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** Months Days 1 □ M 2 🔀 F 169-52-7353 38 1970 Pennsylvania Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10b. County important; if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 XYes 2 No Aberdeen Director MD Harford 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number death with 21001 U.S.A 312 Heron St. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 2 should be filled within 72 hours after on and Mental Hygiene.

Is marked other than "natural", or Iter 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Filomena Sellecchia Fernando D. Pasquale ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important; If item 27 Is m Daniel L. Eustace (Spouse) 312 Heron St. Aberdeen, Maryland 21001 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ Removal from State 12/23/08 Bensalem, PA Resurrection Cemet. 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Tarring-Cargo Funeral Home, P.A.
Aberdeen, Maryland 21001-3399 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on leause on each line. Brain Metastases Approximate Interval Between Onset and Death Immediate Cause (Final e he stotes touce **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Carcinoma Breast Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of): Completed by Physician/Medical the Box ( IF FEMALE: nse 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b Was decedent pregnant 3 Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No Ö 9 Unknown <u>م</u> 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, TITES 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ NO 24a, Was an 1 Yes 2 1√10 or Vital Physician: after death.

Director: After this certific
I in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 Ne 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Hospital or Attending 1 Anatural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ower 30. Name and attress of person who completed cause of death (Item 23a) (Type, Print) 10 Herdeen MROWIE 32. Registrar's Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Doris Etta Feltv 12:15p <sup>™</sup> 21, December 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Carroll Dove House Westminster If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min. Maryland 1 □ M 2 ⋤ F 86 Yrs. 217-18-0864 3/10/1922 Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland nand Mental Hygiene.

is marked other than "natural", or items 23a or 28a-f show' 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 XYes 2 No Director MD Carroll Hampstead 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 1001 Scarlet Oak Ct., Apt 2C 21074 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give ☑ Year or Dates: 1 Never Married 2 Married Specify: white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Completed by 3√ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) department store secretary 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Appleton William Rosser Conley ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 st Department of Health and Important: If item 27 is n any Injury or other traun once. 7996 Brightlight Place Ellicott City, MD 21043 Phyllis L. Bird - daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Carroll Cremation Date 23 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【\*Cremation 3 ☐ Removal from State Maryland, Maryland 2008 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eline Funeral Home M01072 934 S. Main St., Hampstead, Md. 21074 Euro 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ASYSTOLE ENTRICULAR whow Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Thero Scle stic Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ue to (or as a consequence of): Examiner law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 morths? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 ☐ Other (specify) Division or Vital Records, P.O. been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 □ Yes 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an cate has page 2 s performe certificate 2 1 No or Attending Physician: 25. Was case referred to medical examiner? director, 26. Place of Death Check onl one Be To the Hospital or Autonomy
within 24 hours after death.
To the Funeral Director: After this ce Other: 4 Nursing Home 5 Residence 6 Dother (Specify) How 2 No 2 ER/Outpatient 3 DOA 1 TYes 1 Inpatient 10 27. Manny of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 A latural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

WJL

Registrar

31. Date filed (Month, Day, Year)

CHITRACH EDY

distracteder

NAG ANMA 32. Registrar's Signature

DEC 2 3 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 43035 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 11:35 PM oren December 18,2008 /Medical 4a. Facility Name (If not imptitution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** of Maryland Medical Cente Beltimore o. dex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 17 2006 5. Social Security 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Days Months Hours Min. 1 □ M 2 □ √F 214-75-6267 2 MD Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits d other than "natural", or items 23a or 28a-f shovevent, the Medical Evanturer must be multified at Director 1 ☐ Yes 2 📉 No Westminster MD Carroll 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? death with 21157 USA 339 Lemmon Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. filed within 72 hours after 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 XNever Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: Bi-racial Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 h and Mental Hygiene.
7 Is marked other than "1 Elementary/Secondary (0-12) College (1-4or 5+) N/A N/A N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked 1 any Injury or other traumatic ev. once. Kimberly Hare Steven Ferguson ဂ္ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 339 Lemmon Road Westminster, MD 21157 M/M Steven Ferguson/parents 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 12/2472008 1

Burial 2 ☐ Cremation 3 ☐ Removal from State Evergreen Memorial Gardens Finksburg, MD 4 ☐ Donation 5 ☐ Other (Specify) Pritter Funeration Home and Chapel, P.A. Westminster, MD 412 Washington Road 21157 23a. Part1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Mutiogen disease or condition resulting in death) /Medical Due to (or as a nsequence of) Examiner Sequentially list conditions, to the list of the list 3temic law requires that the death certificate be executed Exami sician and burial-trans Due to (or as a consequence of): Records, P.O. Box 68760, the attending physician hed for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown chance Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? certificate Division of Vital Yes 2□No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this To the Hospital or Attending Phywithin 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Secritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D50845 WIL

2

DHMH 17 Rev 1/2001

State Registrar

DEC 2 2 2008

31. Date filed (Month, Day, Year)

dame and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

street

Joseph

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND#SpecINF1-6-09 State of Maryland / Department of Health and Mental Hygiene State AMEND#29d+30perMD, 12/30/00, BMW, McCo Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) 21<sup>Day</sup> 2008<sup>Year</sup> Dec. **Physician** Madeline DeLoach Franklin 23:19 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington Adventist Hospital Montgomery 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1800 al Security Number 141 – 01 – 394 1 **Funeral** Months 1 □ M 2 1 1 F Yrs. 1914 94 Louisiana Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Formation once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County MD Montgomery Chevy Chase No Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 20815 4550 North Park Avenue #T106 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: Black 1 ☐ Yes 2 🔀 No Specify: þ. 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) District of Columbia College (1-4or 5+) Elementary/Secondary (0-12) Teacher Public Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William DeLoach Dora Clay 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 620 Whitingham Drive, Silver Spring, MD 20904 Estelle Franklin - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 12/29/2008 4 ☐ Donation 5 ☐ Other (Specify) Rock Creek Cemetery Washington, D.C. 22. Name and Address of Facility McGuire Funeral Service, Inc. 21. Signature of Funeral Service Licensee Lyne The 7400 Georgia Ave., N.W. Wash., D.C. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence Examine The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): physician Physician/Medical the IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1☐ Yes 2☑No 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9□Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an certificate has autopsy performed 1☐ Yes 2 XNo Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 🗆 Yes 1 Nnpatient 2⊠ No 2 ER/Outpatient 3 DOA ဂ္ this 28a. Date of Injury 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: il or Attending Parent death. (Month, Day Year) 5 Pending investigation 1 A Natural 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Division or Vital Records, P.O. Box 68760,

20

29a. Certifier

29b. Signature and title of certifier

Medical

30 Name and address of person who completed cause of death (Item 23a) (Type, Print) -Kango, M.D. 7600 Carroll Avenue, Takoma Park, MD 20912 31. Date filed (Month 32. Registrar's Signature State 6 Registrar

and manner stated

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year), 12 - 22 - 08

08-09731

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

an Farrell	D	For State Certificate Consistrar	of Death	Reg. N	
Physicia	n/ 1	. Decedent's Name (First, Middle,Last)		Date of Death     Month Day     December 26	2008 Year 1231 hrs
ledical Examin		Jean E. Farrel1  la Facility Name (if not institution, give street and number)  Peninsula Regional Medical Center	4b. City, Town, or Location of Death Worcester		4c. County of Death
Funeral Director		5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs Months Days Hours Min	_	M/DD/YYYY) 9. Birthplace (State or Foreign 930 NEW) Jersey
, and a	1	Usual Residence of Decedent 10a, State 10b, County 10c, City, Town or Loc	ation		10d. Inside City Limits
d how any		Maryland Worcester Ocean P			1 X Yes 2 No
th the Maryland 23a or 28a-f show notified at once.		10e. Street and Number	10f. Zip Code 21811	· 10g. (	Citizen of What Country?  USA
with the ms 23a or be notified		Amed Foresco	Was Decedent of Hispanic Origin? (. S f Yes, specify Cuban, Mexican, Puert	specify Yes or No- p Rican, etc.)	14. Race - American Indian, Black, White, etc.
hours after death with the Maryfand natural", or items 23a or 28a-f she Examiner must be notified at once	by Funeral	Never married 2 married 1 Yes 2 X No 1 Yes 3 Y Widowed 4 Divorced If Yes, Give Year or Dates 1	Yes 2 X No specify:		Specify: white
	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	g most of working life. DO NOT use re		domestic
15-0036 filed within 72 l al Hygiene ed other than " t, the Medical I	Be Com	12 – Hon 17. Father's Name (First, Middle, Last) William Evansen	18.Mother's Nam	e (First, Middle, Maid	den Surname)
, MD 21215-0036 and 2 should be filed within 72 eath and Mental Hygiene. tem 27 is marked other than traumatic event, the Medical	ToB		Street and Number of Blue Bill Ct., I	Berlin, MI	21811
re, s l an of Hea If iten	2300	1 X Burial 2 Cremation 3 Removal from State Glenwood	position (Name of cemetery, other place) Memorial	/31 /08	Broomall, PA
Baltimore, permit: Pages 1 ar Department of Hee Im ortant: If ite	1	21. Synature of Funeral Service License 2.	2 Name and Address of Facility HOLLOWAY Funeral 501 Snow Hill Rd	Home Prof	essional Association ary, MD 21804
Physician 'Medical aminer		23a. Part I. Enter the disease, or complications that caused the death. Do not ent failure. List only one cause on each line.  Immediate Cause (Final disease a. Multiple Injuries	er the mode of dying, such as cardiac	or respiratory arrest	, shock, or heart Approximate Interval Between Onset and Death
ammer		or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions,  b.		*	
ed .	Examine	(Disease or injury that initiated events resulting in death) Last			
60, ate be executed hysician and te burial - transit	Medical	d. UNPENDED AMENDED			
Division of Vital Records, P.O. Box 68760, pital or Attending Physician: The law requires that the death certificate be executed ours after death. After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial – trans	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 ✓ Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Pregnant at time of death 5 Unknown	Fetal death 3 Ectopic pres	gnancy	23d. Date of delivery Month Day Year
P.O. B. that the degree by the detached is	by Phy	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.		acco use contribute to the cause of death?  2 No 3 Probably 4 Unknown
Division of Vital Records, P.O. E the Ilospital or Attending Physician: The law requires that the hin 24 hours after death. After this certificate has been signed by the Functor in the Funcarial Director: After this certificate has been signed by the placety filled in by the funcal director, page 2 should be detached.	Completed			24a. Was an autopsy perform	prior to completion of cause of death?
Rec The liftcate	Co	25. Was case referred to medical	26.Place of Death (Che	1 Yes 2	No 1 Yes 2 No
/ital /sician uis cert directo	o Be	examiner? 1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ✓ ER/Outpa	ntient 3 DOA Other Nu		tesidence 6 Other:
n of \\nding Phy th. :: After the funeral of tuneral of	ion: To		e of Injury 28c. Injury at Work?  1 Yes 2 No	28d. Describe ho Driver involve	ow injury occurred ed in collision
Division at or Attend as or Attend as after death.	Certification:	2 M Accident Investigation 3 Suicide 6 Could not be determined (Specify) Major Road / High		28f. Location (St or Town, Sta West Bound O	reet and Number or Rural Route Number, City ate) cean Gateway , Salisbury , MD
the Hos hin 24 h the Fun		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death of one) 2 ✓ Medical Examiner:On the basis of examination and/or investigation.	occurred at the time, date and place.	and due to the cause ed at the time, date a	(s) and manner as stated. nd place, and due to the cause(s)
To To To To Com	Mec	and manner stated.  29b. Signature and title of certifier	29c. License number		29d. Date signed (Month, Day, Year)
		Patri Un-Poller m	O.C.M.E.		December 27, 2008
1,aly		30. Name and address of person who completed cause of death (Item 23a)  Patricia Aronica-Pollak MD. Assistant Medical Examine	er 111 Penn Street, Baltin	nore, MD 21201	
	State		Coarle		
Regi	डावि		A COLUMN TO THE PARTY OF THE PA		

DHMH 17 Rev 1/2001 OCME 2006

OCME

State Registrar 30. Name and address of person

29838

Ħ

MARJORIE

GREEN,

Old Washington Kd

to completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			State of Ma	ryland	-	rtment of F <i>tificate of l</i>						1,2020
	_		1. Decedent's Name (First, Middle, Last)		- Cei	inicale of	Deali		2. Date of De	Reg. No	2008	4 3 0 3 9 3. Time of Death
	Physicia		MARJORIE ANN	GRAY					Month DEC.	Day 20		
na it	/Medic Examin		4a. Facility Name (If not institution, give street and number)	Oldii		4b. City, Town, o	r Location	n of Death	DEC.		County of Dea	
ange of			WASHINGTON ADVENTIST HOS					PARK			MONTGON	
	Funeral		1 □ M 2 1 F		st birthday) Yrs.	If Under 1 Year Months Days	Hours	Min.	8. Date of Bir (Month, Da	ay, Year)		rthplace (State or Foreign country)
	Director		220-12-3109 Usual Residence of Decedent	83					JAN. 2	8, I	925  WA	ASH. D.C.
	yland yland		10a. State 10b. County	10c. City,	Town or Loc	ation						10d. Inside City Limits
	Ba-f s	Director	MD. PRINCE GEORGES		HY	ATTSVILI	LE					1 XYes 2 No
	ith th	Dire	10e. Street and Number			10f. Zip Code				10g. Citi	zen of What C	·
	sath v	Funeral	5805 42nd AVE. #501	vor in 11 S	13 V		)781	Origin? (Spe	cify Yes or No	.	U.S.A.	
40	ter de	Fun	Armed Forces?		,	Vas Decedent of H Yes, specify Cuba	an, Mexic	can, Puerto F	Rican, etc.)	, I	Black, Whi	
036	urs ar	þ	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:		1	□Yes 2□XNo	Speci	fy:			Specify:	WHITE
21215-0036	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show fiest Evant institution	Completed	15. Decedent's Education (Specify only highest grade completed)		(Give I	ent's Usual Occup	durina m	ost of workin	g	16b. Ki	nd of Business	s/industry
121	vithin ene. <b>than</b> "	ldm	Elementary/Secondary (0-12) College (1-4or 5+	-)	life. E	O NOT use retired HOMEMAR					HOM	A C
	filed v Hygie other t		11   17. Father's Name (First, Middle, Last)			HOMEMAN		ther's Name	(First, Middle	, Maiden		112
lan	ld be lental ked c	To Be	WILLIAM W. HARDY	7				BL	ANCHE	Α.	STAC	CK
Maryland	shou and N s mar	-	19a. Informant's Name/Relationship (Type. Print)		19b. Mailin	g Address (Street	and Nun					
	and 2 ealth n 27 i		MARJORIE ANN GRAY/SELF		_5805_						LE, MD.	
ore	ges 1 It of H If iter or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	20b. Pla	ace of Dispos metery, crem	sition (Name of natory or other plac	ce)	Da	ate	20c. Lo	ocation - City o	r Town, State
altimore,	it. Pa rtmen rtant: njury		4 ☐ Donation 5 ☐ Other (Specify)	WAS		NATL					ITLAND,	
Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show am portant: an interest in the conference of the real matter than "net in the real bar. The an once."		21. Signature of Funeral Service Ligensee	10009	1   ČI	Name and Addre HAMBERS I 301 CLEVE	TÜNET ELANI	RAL HO O AVE.	ME & C , RIVE	REMA' RDAL	TORIUM, E, MD.	P.A. 20737
			23a. Part 1. Enter the disease, or complications that caused t shock, or heart failure. List only one cause on each inc	the death.	Do not ente	er the mode of dyin	ng, such	as cardiac o	r respiratory a	ırrest,		Approximate Interval Between Onset and Death
ma.	Physician		Immediate Cause (Final disease or condition resulting in death)	3720	rah	1 08	7-81	ino	hu			
<i>'</i>	/Medical Examiner		Due to (or as a	conseque	ence of):							
Ļ		Jer	Sequentially list conditions, b.	conseque	ence all							
В	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events  c									
90,	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Ë	resulting in death) Last Due to (or as a	conseque	ence of):							
68760,	ficate physi s the t	edical	d									
Box (			IF FEMALE: 23c. If yes, outcome of the control of t			1					23d. Date of d	elivery
	death e atte	Physician/M	in the past 12 months?  1 □ Ves 2 □ Oregnant at			Ectopic pregnand Other (specify) _	<u>.</u>			- 1	Month	Day Year
P.0.	at the I by th	hys	9 ☐ Unknown				=		00 0:11			
	w requires that s been signed I s should be det	by	Part II. Other significant conditions contributing to death but	t not result	ting in the ur	derlying cause giv	en in Pai	rt I.	23e. Did 1			to the cause of death?  Probably 4 □ Unknown
Š	requi	Completed	- John Gra		***				Z			
Rec	has as a second	μ	Molnutari-	fr.1	1				24a. Was auto perfo		prior to death?	autopsy findings available o completion of cause of
ā	ificate	ပ္ပို	25. Was case referred to medical	16119	rus		26 81	and of Dooth	1 □ Yes (Check only o	2 No	1 □ Ye	s 2 No
<u>&gt;</u>	Physician: The la r this certificate had ral director, page 2	m	examiner?	nt 2 🗆 E	ER/Outpatien	t 3 DOA Oth					6 □Other (Sp	necify)
0 0	ng Ph fter th neral	J:uc	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 28a. Date of Injur (Month, Day)	y 2 Year)	28b. Time of Injury	28c. Inju Wor			8d. Describe	-		
Sio	tendii eath. or: A the fu	catic	2 Accident investigation	-		M 1 □	Yes 2					
Division of Vital Records,	or At after d Direct in by	Certification: To	4 Homicide determined 28e. Place of Injurbuilding, etc.			eet, factory, office		2	8f. Location ( City or To			Rural Route Number,
	To the Hospital or Attending Physician: The law requires that the death certi within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a		29a. Certifier 1 Certifying Physician: To the best of (Check only 2 Medical Examiner: On the basis of	f my know	vledge, death	occurred at the ti	ime, date	and place, a	and due to the	cause(s	) and manner	as stated.
	the H thin 24 the Fi mplete	Medical	one) and manner stat		>	29c. Licens						nth, Day, Year)
	P 3 P 8		29b. Signature and title of certifier	>	ign	Too. Livelis	)U	560		Dd	12 -	2608
	7		30. Name and address of person who completed cause of de	ath (Item	23a) Type.	Print) PK - D	PIN	DER	SINO	H, n	UD.	20 20 115
			1436C/CAU	Ar	5	Fex	1	N, 1	V4 (	>0.	e-ie	(1) (0-)/
	Sta			r's Signatu	ure							
	Registr	ar	DEC 2.4 2008 / Parent	2 65	Action	MARY J						

Registrar
DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Fede Margherita Betti Giuliani December 2008 1:20  $p^{M}$ /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery

9. Birthplace (State or Foreign Country) Potomac Year I If Under 24 Hrs. Byron House 6. Sex 7. Age (In yrs. last birthday) If Under 1 8. Date of Birth (Month, Day, Year) Social Security Number **Funeral** Hours Min Months Days 1 □ M 2 1 F 578-46-8738 97 July 11, 1911 Italy **Director** Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 28a-f show d 2 should be filed within 72 hours after death with the Maryla th and Mental Hygiene. In amarked other than "natural", or items 23a or 28a -f shov traumatic event, the "section Exam her must be notified at 1 □Yes 2 N No Director Maryland Montgomery Potomac 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20854 USA 9210 Kentsdale Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2√2 If Yes, Give Year or Dates: 2 X No 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify Specify þ ₩Widowed 4 Divorced White Completed Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Paradisa Simoni Adamo Betti 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2
Department of Health a
Important: If item 27 Is
any injury or other tra Benjamin W. Giuliani/Son 22 River Fall Court, Potomac, MD 20854 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 x Burial 2 ☐ Cremation 3 ☐ Removal from State Dec. 2 2008 24, St. Gabriel's Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Potomac, Maryland 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licensee 500 University Blvd. W., Silver Spring, MD 20901 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** 10 years disease or condition resulting in death) Chronic Anemia /Medical Due to (or as a consequence of): Examiner 40 years Sequentially list conditions, if any, leading to immediate cause. Enter or desting Cause (Disease or injury that initiated events resulting in death) Last Hypertension Due to (or as a consequence of): be executed Exami the burial-transi and Due to (or as a consequence of): Box 68760, physician Physician/Medical certificate use as t nding p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant death 3 Ectopic pregnancy atter for in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) o. certificate has been signed by the rector, page 2 should be detached 9 Unknown The law requires that the 9 Unknown σ. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

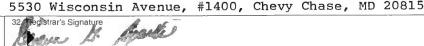
1 □Yes 2 □No 24a. Was an autopsy performed? 1 ☐ Yes 2 😧 No Hospital or Attending Physician: The hours after death. Funeral Director: After this certificate tely filled in by the funeral director, par 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Assisted 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Living Injury 1 😿 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral C Hospital 29a. Certifier 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

31. Date filed (Month, Day, Year)
DEC 2 4 2008

Deidra Woods, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



D54241

December 22, 2008

			1 - State Registrar		(	Certific	cate of	Death		Reg. No	108	43041
	Physici /Medic		1. Decedent's Name (First, Middle, Elizabeth M.	Last)	Garraw	әу			2. Date of D Decemb	eath er 149,	2008	3. Time of Death 11:50A. M
and.	Examir		4a. Facility Name (If not institution,	give street and number)		4b.	City, Town, o	r Location of Death	1	[	nty of Death	
1			8670 Piney Branch					Spring	T	Mor	tgome	
	Funeral Director		212-04-0598	1	e (In yrs. last birth		nder 1 Year nths Days	If Under 24 Hrs. Hours Min.	8. Date of B	,1925	_ Cou	place (State or Foreign htry) Inicə
	pui 💉		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location						10d. Inside City Limits
	e Maryla Ba-f shor	ctor	Maryland Montgo	mery	Silve	r Spr	ing					1 □Yes 2 No
	th with th	Funeral Director	10e. Street and Number 8670 Piney Bran	ch Road, #2	01	10	f. Zip Code 2(	0901		10g. Citizen d United		
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, if a Hodical Exaction to it. In Middled Exaction to it. In Middled Exaction to it.	ğ	11. Marital Status 1 □ Never Married 2 □ Marrie 3 ☑ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 \( \text{Yes} \) 2 \( \text{M} \) If Yes, Give Year or Dates:	Ever in U.S.		Decedent of H specify Cub es 2 XNo	Hispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or N o Rican, etc.)		lace - Americ lack, White, cify: Fre	
5-0	72 hc	Completed	15. Decedent's (Specify only highest	Education grade completed)	16a. [	Decedent's Give kind o	Usual Occup of work done	pation during most of wor d)	<i>ki</i> ng	16b. Kind of	Business/In	ndustry
121	vithin	dm	Elementary/Secondary (0-12)	College (1-4or 5	+)	life. DO No <b>1t</b> Ca		d)		Coris	trics	
2	iled w Hygie ther t	ပိ	17. Father's Name (First, Middle, La	act)	Add	IL Co	,re	18. Mother's Nan	ne (First, Middle			
yland	uld be f Mental I arked of atic eve	To Be	Winfred Laronde					Philomen				
Mar	alth and 2 sho		19a. Informant's Name/Relationshi Fitzroy Bertrand		1 <sup>19b.</sup> 128	Mailing Add 07 Ir	dress (Street nnisbro	and Number or Ru ook Drive	ral Route Num Beltsv	ville, N	n, State, Zij laryla	nd 20705
Baltimore, Maryland 21215-0036	Pages 1 annont of He ant: If item		20a. Method of Disposition 1		20b. Place of E cemetery Marylan				Date k 12/27	20c. Locatio 7/2008 I		own, State , Maryland
Balt	permit. Departr Imports any inji		21. Signature of Funeral Service Li	censee / Barre	vell	22. Nan Dona 4400	ne and Addre	ess of Facility Borgward	t Funer	al Home	, PA Mar	yland 2070
			23a. Part1. Enter the disease, or c shock, or heart failure. List or	omplications that caused	the death. Do no						., 1101	Approximate Interval Between
	Physician /Medical Examiner	er	Immediate Cause (Final disease or condition resulting in death)	a. <u>Ventri</u> Due to (or as a	cular Ar a consequence of olyte Im a consequence of	):  bə1ər						Onset and Death
	uted	Ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Renal	Failure							
, G	exectan an an ial-tra	Examiner	that initiated events resulting in death) Last		a consequence of	):		******				-
68760,	certificate be executed ding physician and se as the burial-transit	/Medical	^\	d. <u>Heart</u>	Failure							
×	the Hospital or Attending Physician: The law requires that the death certif hin 24 hours after death.  the Funeral Director: After this certificate has been signed by the attending the Funeral Director. After this certificate has been signed by the attending the funeral director, page 2 should be detached for use as appletely filled in by the funeral director, page 2.	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1  Live birth 4  Pregnant al 9  Unknown	2 Fetal death		opic pregnancer (specify)	су		1	Date of deliv	very Day Year
of Vital Records, P.	uires that signed b d be deta	ò	Part II. Other significant condition Diabetes Mellitu	s contributing to death bu	ut not resulting in t	the underly	ing cause giv	en in Part I.				the cause of death?
Ö	w requir	Completed							24a. Wa	s an 24	b. Were auto	opsv findings available
Re	he lav e has	m d							auto	opsy formed?	prior to co death?	opsy findings available empletion of cause of
Ē	sician: The certificate h rector, page		25. Was case referred to medical			<del></del>	<u> </u>	26. Place of Dea		2 🟋 No	1 □Yes	2 LXNo
5	lysicia lis cer direct	o Be	examiner? 1 ☐ Yes 2 ☐XNo	Hospital: 1  Inpatie	ent 2 ER/Out	patient 31	DOA Oth			sidence 6 🗆 0	)ther (Sneci	f <sub>V</sub> )
0	g Physer this	n: To	27. Manner of Death	28a. Date of Inju (Month, Day			28c. Inju Wor			how injury occ		.,,,
io	ath. r: Aft	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investiga		y, rear) III]	M.	1 1 🗆	Yes 2 □No				
Division	after des Directo	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		ury - At home, farr c. (Specify)	n, street, fa	actory, office		28f. Location City or To	(Street and Nui own, State)	nber or Run	al Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical C		Physician: To the best of xaminer: On the basis of and manner sta	f examination and							
	<b>Го th</b> i within То the хотрі	Me	29b. Signature and title of certifler				29c. Licens	se number		29d. Date sig	ned (Month,	Day, Year)
	10		1					6147		12	122	108
			30. Name and address of person w	ho completed cause of d	eath (Item 23a) (1	ype, Print)		0111		1 5	1-10	100
		L	Nasreen M. Kango	, M.D. 7610	Carroll	. Aver	nue,#20	05 Takoma	Park,	Mərylər	id 209	12
	Sta	ite	31. Date filed (Month, Day, Year)	32 Registra	ar's Signature	1	The same of the sa					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death , Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month Gesila R. Grant 2008 4c. County of Death Facility Name (If not institution, give street and number, Hospic at the comico DUY If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Days Hours Months 1 ☐ M 2 🕱 F 214-80-5507 Aug 31, 1961 MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 1 TYYes 2 □ No Worcester Snow Hill MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21863 USA 5734 Blake Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 □ Yes 2 □ No Specify Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) **5+** Elementary/Secondary (0-12) Health Educator University 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harry Wesley Henry Lucille Blake Henry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) Samuel A. Grant/husband 5734 Blake Rd., P. O. Box 45, Snow Hill, MD 21863 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/27/2008 Wesley UMC Cem Snow Hill, MD 22. Name and Address of Facility Lewis N. Watson Funeral Home 1618 West Rd., Salisbury, MD 21. Signature of Funeral Service Licens Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final neta Sta disease or condition resulting in death) Due to (or as a consequence of): MODENIC Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No 9 Unknown Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes \_2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy perform ,21 1 □Ye*s* 25. Was case referred to medical 26 Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) DSD[ 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 ☐ Accident

Physician /Medical Examiner Examine law requires that the death certificate be executed

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

Director

Funeral

þ

Completed

Be

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, If a Medical Evantmer must be neffled at

resila crant limore, Maryland 21215-0036

burial-tran and physician the as nse for cate has been signed by page 2 should be detach certificate this

Box 68760.

P.O.

Division of Vital Records,

funeral director,

Physician/Medical þ Completed Be Certification: To

To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After Medical

filled in by the

31. Date filed (Month, Day, Year) Registrar

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sohrim anuelles Coastal

and manner stated.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

DEC 2 9 2008

6 ☐ Could not be determined

ORIGINAL

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) December 30, 2008 **Physician** 1940 Jacqueline Cordes Haas /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford Havre de Grace Harford Memorial Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Min. **Funeral** 1/27/1949 Months Days Hours Kansas 1 □ M 2 🛛 F 59 221-34-5786 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 1 XYes 2 No Director Aberdeen Harford MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21001 43 Hillman Court Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married Married 1 ☐ Yes 2 No Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Public Schools Superintendant permit. Pages 1 and 2 should be filed win Department of Health and Mental Hyglens Important: If item 27 is marked other tha any Injury or other traumatic event, the Jonce. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21001 43 Hillman Ct. Aberdeen, Maryland James Haas (Spouse) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State 1/02/09 West Chester, PA R. A. Ferris & Co 4 □ Donation 5 □ Other (Specify) 21. Signature of Fund ral Service Lice 22. Name end Address of Facility Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399 and 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** MYOCARDIAL INFARCTION disease or condition resulting in death) ACUTE /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy Day Month Year 5 ☐ Other (specify) 4☐Pregnant at time of death 1 ☐ Yes 2 🗷 No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ SEVERE ASTHMA, ITYPERTENSION 1 ☐ Yes 2 INo 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No ATOPIC DERMATITIS 24a. Was an SEVERE autopsy 1☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No

and P.O. To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been sign completely filled in by the funeral director, page 2 should be the Hospital or Attending Physician;

filed within 72 hours after death with the Maryland Hygiene. sther than "natural", or items 23a or 28a-f show

Maryland 21215-0036

Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

15

State

29b. Signature and title of certifier

Melyary

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

D45344

29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001 **ORIGINAL**  Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

	1 - For State Registrar  1. Decedent's Name (First, Middle, Las	State of Maryland	/ Departme		and Mental Hy	giene Reg. No. 2008	
Physician /Medical Examiner	STEVEN  4a. Facility Name (If not institution, give	street and number)	10.0	y, Town, or Location of	Month DECEN	Day Year	-1700
Funeral Director	5. Social Security Number 6. St 216–46–7246 1  Usual Residence of Decedent			PACTINE 1 Year If Under Son Days Hours		, 1949 Mas	thplace (State or Foreign ountry) S.S.
or 28a-f show oe notified at Director	10a. State 10b. County Maryland Baltimo		own or Location	En Codo		10. Cilina efilita e	10d. Inside City Limits 1 ☐ Yes 2 ☒ No
fter death with triems 23a or intermust be or Funeral Dir	2907 Dunmore Ro	ad  12. Was Decedent Ever in U.S. Armed Forces?	13. Was Dec	ip Code 21222 edent of Hispanic Oriectly Cuban, Mexican	gin? (Specify Yes or No-	10g. Citizen of What Council USA  14. Race - American Black, White	erican Indian,
72 hours afte natural", or it iscal Example eted by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced  15. Decedent's Ed (Specify only highest gra	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:  ucation  the completed)	1 □Yes	2 No Specify:			White
be filed within 72 hou tal Hygiene. d other than "natura svent, the Medical E	Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last)	College (1-4or 5+)	Machi		r's Name (First, Middle,	Private  Maiden Surname)	
d 2 should be th and Menta if is marked traumatic ev	Joseph J.  19a. Informant's Name/Relationship (7)  Albert R. Harmon	**			Lillian er or Rural Route Number 14, San Die		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be rollified at once.  To Be Completed by Funeral Director	20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specify  21. Signature of Funeral Service Licen	Removal from State Balti Cong	e of Disposition (Netery, crematory, or MOTE HED: regation	ame of cother place) rew Cemetery	Date 12/24/08	20c. Location - City or	Town, State
Physician	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition	lications that caused the death. I	11800 Do not enter the m	New Hamps ode of dying, such as	hire Ave.,	Silver Spri	Approximate Interval Between Onset and Death
le be executed skician and e burial-transit e burial-transit cal Examiner	resulting in death)  Sequentially list conditions, if any, leading or immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. CHRONIC Due to (or as a consequent  C. MULTIOR  Due to (or as a consequent  C. HRONIC  C. HRONIC	ice of):  ST2UC  SAN 54  ce of):	TIVE PLAN	AILURO	SISENSE	ZUEEKS
nat the death certificate d by the attending physetached for use as the Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d	y eath 3□Ectopid	pregnancy		23d. Date of de Month	livery Day Year
equires that the sen signed by ould be detailed by the ted by Ph	Part II. Other significant conditions of	-	ng in the underlying	cause given in Part I.		es 2 No 3 P	o the cause of death?
an: The law requir tificate has been s tor, page 2 should e Completed	25. Was case referred to medical			GC Place		sy prior to death? 2 \( \) No 1 \( \) Yes	utopsy findings available completion of cause of
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Medical Certification: To Be Completed by Physician/Medical Examir	examiner?	(Month, Day, Year)	b. Time of Injury M	OCA Other: 4 \( \text{Nu} \)  28c. Injury at Work?  1 \( \text{Yes} \) 2 \( \text{In} \)	40	ence 6 Other (Specow injury occurred	
the Hospita Ithin 24 hours the Funeral Impletely filler	29a. Certifier (Check only one) 1	vslcian: To the best of my knowle iner: On the basis of examination and manner stated.	and/or investigation	ed at the time, date an on, in my opinion, deat 9c. License number	th occurred at the time, o	date and place, and due	e to the cause(s)
5	30. Name and address of person tho	ompleted cause of teath (item 23		RES.	000	ecember	- 0 0 00
State Registrar	31. Date filed (Month, Day Year) DEC 2 6 2	Oatz M.D. 49 40 2008 32. Registrar's Signature		EN AVE	INUE BAL	TI-NORE!	MD 21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State	of Marylan		artment of rtificate of		d Mental Hyg	giene Reg. No. 200	8 430	46
			Decedent's Name (First, Middle	e, Last)					2. Date of Dea	109.1107	3. Time of De	eath
	Physicia	an	Joo Young	In					Month	er 15, 2008	r	рм
	/Medic		4a. Facility Name (If not institution		mher)		4h City Town	or Location of De		4c. County of De		1
	Examin	er	,		ŕ	,						
-	Euporol		Shady Grove A  5. Social Security Number	6. Sex	7. Age (In yrs.		Rockv If Under 1 Year			Montgo	omery irthplace <i>(State or F</i> e	oreian
	Funeral Director		366-06-3133	1 🖾 M 2 🗆 F	6	Vm	Months Days	Hours Mi	in.   (Month, Da)	r, Year)	Country)	o.o.gii
			Usual Residence of Decedent	-	0	0			Nov. 17	, 1940   K	orea	
	ylanc **		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation				10d. Inside City L	imits
	Mar I st	tor	Maryland Montg	omery	G	ermanto	own				1 ☐ Yes 2 [	⊠ No
	r 288	irec	10e. Street and Number				10f. Zip Code			10g. Citizen of What 0	Country?	
	3a o	a D	20812 Gaelic	Court			20874			United S	States	
	ms 2	Funeral Director	11. Marital Status	12. Was Dec	edent Ever in U.	S. 13. V		Hispanic Origin?	(Specify Yes or No- erto Rican, etc.)	14. Race - An	nerican Indian,	
0	or ite	Fu	1 ☐ Never Married 2 ☐ Marr	ied Armed F	2 🔀 No				erto Rican, etc.)		ite, etc.	
0000	al", c	by	3 X Widowed 4 ☐ Divorced	If Yes, G Year or I	ive Dates:		I∐Yes 2⊠No	Specify:		Specify: As	ian	
- -	72 ho natur lical	sted	15. Decedent	t's Education			lent's Usual Occu kind of work done		varbina	16b. Kind of Busines		
7	an "i	pdr B	Elementary/Secondary (0-12)	T	1-4or 5+)	life. L	DO NOT use retire	ed)	VOIKING			
7	g with	Completed		Ĭ, Ž		Ac	<u>cupunctu</u> :	cist		Oriental	Medicine	
9	be lied within 72 hours after death with the Maryland the Hygiene. do other than "natural", or items 23a or 28a-f show event, the Madical Even increments.	Be (	17. Father's Name (First, Middle,	Last)				18. Mother's N	lame (First, Middle,	Maiden Surname)		
	uid b Ment Irked Itic e	2	Kapyoon	In				Dongy	eo	Kim		
a	sho s ma		19a. Informant's Name/Relations	nip (Type. Print)		19b. Mailin	g Address (Stree	and Number or	Rural Route Numbe	r, City or Town, State	Zip Code)	
Σ .	and 2 alth 127 i		Sung Yong In	/ Son		20812	Gaelic	Court: (	Germantow	. MD 2087	4	
e,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Immortant: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Eventual Eventual by an illihed at once.	1 .5	20a. Method of Disposition	- 7-	20b. F		sition (Name of natory or other pla		Date	20c. Location - City of		
Dallimor	Page	/	1 ☐ Burial 2 X Cremation 4 ☐ Donation 5 ☐ Other (S)		State			· · · · · · · · · · · · · · · · · · ·	/22/2008	Brentwood	MD	
= =	partn Sorta / inju		21. Signature of Funeral Service	Licensee		22	. Name and Addr	ess of Facility S	imple Tri	btue	TID	1
Ŏ	Depar Impor any ir	. 3	VI SA						_	ille, MD 2	0852	3
			23a. Part 1. Enter the disease or	complications that	caused the deatl						Approximate	
	buoisian	2	shock, or heart failure. (*) ist Immediate Cause (Final disease or condition	only one cause on	each line.	120					Interval Betwee Onset and Dea	
1	hysician /Medical		disease or condition resulting in dea	a. Dua to	(or as a consequ		ocard	1 / 2	U garc.	TION	minu	146
E	xaminer				( n			· 1			( .	
		ē	Sequentially list conditions,	b. Due to	(UI da a CUIISEU		mell	1743			Sear	3
1	ured insit	i i	cause (Disease or injury that initiated events	12	LOEV (	hale	sterc	1000			year	rs
	n and al-tra	Examiner	resulting in death) Last		(or as a consequ		31010	, CVV				
00,	cate be executed physician and the burial-transit	dicall										
0	g phy	edic		a								
X I	attending p	sician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou	tcome of pregna	ancy				23d. Date of d	elivery	
0	atte for u	ciar	in the past 12 months?		birth 2 Feta		Ectopic pregnan Other (specify)	су		Month	Day Yea	ır
o į	y the	hysi	1 □ Yes 2 □ No 9 □ Unknown	9 □ Unk			(-p/) -					
L :	w requires intaining to been signed by the should be detached	٥	Part II. Other significant condition	ns contributing to a	leath but not resu	ulting in the ur	nderlying cause gi	ven in Part I.	23e. Did to	bacco use contribute	to the cause of deatl	:h?
3	sign sign d be	d by							1 □ Y	es 2 □ No 3 □ I	Probably 4 3 Unix	nown
ecords,	beer	Completed							_	1		
בַּ	has he 2 s	ldm							24a. Was a autop: perfor	sv   prior to	autopsy findings avai completion of caus	
5	icate ; pag	S									s 2 <del>10</del> 0	
\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	aning Frigstoan.  After this certificate h. funeral director, page	Be	25. Was case referred to medical examiner?	Hospital:			To:	-	eath (Check only or	ne)		
5	this aldir	2	1 ☐ Yes 2 ☑ 110	1 1 1	Inpatient 2 🗔		1 3 DOW			ence 6 ☐ Other (Sp	ecify)	
	Affer	Ö	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	9	nth, Day, Year)	28b. Time of Injury	28c. Inju	rk?	28d. Describe h	ow injury occurred		
	tor:	cat	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could r	ot ho				Yes 2 □No				
2	fter c	Certification:	4 Homicide determ	ined 28e. Place build	e of Injury - At ho ling, etc. <i>(Specif</i>	ome, farm, stre <i>ly)</i>	eet, factory, office		28f. Location (S City or Tow	treet and Number or I n, State)	Rural Route Number,	,
ב ב	urs a		00- 0-45 453 411						1			
	The hospital or Autonomy Priystoan: The law requires that the beath certain 2 of the Purporal of the clear.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier 1 Certifyin (Check only one) 2 Medical	Examiner: On the I	basis of examina	wiedge, death ition and/or inv	n occurred at the f vestigation, in my	ime, date and pla opinion, death oc	ace, and due to the o ccurred at the time, o	cause(s) and manner date and place, and du	as stated. ie to the cause(s)	
,	thin 2 the mple	Med			nner stated.		00- 11	a number		Ood Date of and 1/44:	oth Day V1	
F	P	_	29b. Signature and title of certifier	1 227			29c. Licen			29d. Date signed (Mor	- ,	
	3		Melecac	h) X he	nill	np	03	6970	3	Lecene	un 15, 2	SOC
			30. Name and address of person	who completed cau	se of death (Item	n 23a) (Type, F	Print)					
			webrahsh	emilm	9901	Medi	(c) (e)	1 terpy	c. Rocki	Deceme Lille, m	02085	20
	Sta		31. Date filed (Month Day, Year)	2008	egistrar's Signa	ture	STAR R					
	Registra	:11		14	AND THE STATE OF	PHO OF THE PROPERTY OF	STATE OF THE PARTY					1

## Over High Jones

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

IK UNK	1	Stat - For State	e of Maryland		ate of D		ai i iygici	Reg. N		
Physicia	B	egistrar Decedent's Name (First, Middle, I	ast)	Ochino				te of Death		B. Time of Death O
Physicia edical Examir		Owen Hugh Jor					De	nth Day cember 21		1205 hrs
		a. Facility Name (if not institution,				City, Town, or Location of I	Death		4c. County of Deatl Frederick	h
		Island on Potomac Rive				runswick	044   0 5	at at Diale (a	M/DD/YYYY) 9. Bi	rholace (State or
Funeral Director		215-94-0910	Sex 7. Ag	ge (In yrs. last bir	//	Under 1 Year If Under  Months Days Hours	Min	uly 6,	Forei	gn Duntry) Maryland
×	-	Usual Residence of Decedent  10a, State 10b, County		10c. City, Town	or Location					10d. Inside City Limits
ow any						n				1 Yes 2 X No
Maryland 28a-f show d at once.	후	Maryland Mo  10e. Street and Number	ontgomery	Ken	singto	of, Zip Code	<del></del>	10g. (	Citizen of What Cou	untry?
ith the Maryland 23a or 28a-f sho notified at once.	Director	4007 Simms Dr	ive			20895			USA	
with th		11. Marital Status	12. Was Deceder		13. Was D	ecedent of Hispanic Origin specify Cuban, Mexican, F	n? ( Specify Puerto Rican	Yes or No-	14. Race - Ame White, etc.	rican Indian, Black,
death rr iten	Funeral	1 XNever Married 2 Mar	1 Yes 3	X No		_		, ,	Specify: Wh:	ite
after aff, o	by F	-	ced If Yes, Give Year or Dates:	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		s 2 X No specify:  Usual Occupation (Give ki	ind of work d	one 16	b. Kind of Business	
hours afte 'natural'', Examiner	pg .	15. Decedent's Education (Specific Elementary/Secondary (0-12)	College (1-4 or		during most	of working life. DO NOT u	ise retired)			
36 thin 72 than "	plet	12	College (1-4 of		unknow	1		١,	unknown	
5-0036 led within 72 Hygiene. other than the Medical	Completed	17. Father's Name (First, Middle, L	ast)			18.Mother's		t, Middle, Maid	den Surname)	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be	Dennis W. Jon	es			lois M				
Baltimore, MD 21215-0036 permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	٩	19a. Informant's Name/Relationshi Dennis W. Jone	p (Type, Print ) s/Father	1'	9b. Mailing A 4007	ddress (Street and Numb Simms Driv	e, Ker	nsingto	on, MD 20	895
e, Nad I and Health item	- 1	20a. Method of Disposition		I	e of Disposition	n (Name of cemetery, place)	Dat	e 24 2	0c. Location - City of	or Town, State
ages of other		1 Burial 2 X Cremation 4 Donation 5 Other Spe		State	•	an Cremator		1	Alexandr	ia, Virginia
Baltimore, permit Pages 1 ar Department of Hee Important: If ite	2	21. Signature of Funeral Service L			22 Nan	ne and Address of Facility	lins E	uneral	Home In	c.
III De Per QQ		Janus &	Coole		500	) University	Blvd.	. W., S	Silver Sp:	ring, MD 209  Approximate Interval
Physician		23a. Par I. Enter the disease, or of failure. List only one cause of	n each line.			mode of dying, such as ca	ardiac or resp	oratory arrest,	SHOCK, OF Heart	Between Onset and Death
Medical Examiner		Immediate Cause (Final disease	a. Contact Guns		of Head					2000
		or condition resulting in death)	Due to (or as a cor	nsequence of):						
	ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a cor	nsequence of):						
	Examiner	(Disease or injury that initiated	c. Due to (or as a cor	sequence of):						+
recuted and rand		events resulting in death) Last	d.							
D, be executed sician and ourial - transi	edical	UNPENDED	AMENDED							
<b>60,</b> ate be exhysician te burial	Med	IF FEMALE:	23c. If yes, outo	come of pregnance	су				23d. Date of deliv	
Box 6876( be death certificate the attending physical for use as the b	Physician/M	23b. Was decedent pregnant in the past 12 months?		at time of death			pregnancy		Month	Day Year
Box e death c the atten ed for us	sic	1 Yes 2 No 9 Unk	7		5 Othe	r (Specify)				
O. B trithe d by the	P.	Part II. Other significant conditi	ons contributing to de	eath but not resul	Iting in the un	derlying cause given in Pa	art I.			to the cause of death?
ires that the signed by I be detached	g						}	1 Yes		Probably 4 Unknown
'ds, requir	Completed							24a. Was an autopsy	24b. Were	autopsy findings available to completion of cause of
cor e law e has l	臣							perform 1 ✓ Yes 2		
tal Reco		25. Was case referred to medical				26.Place of Death	(Check only	one)		
Vital I hysician: this certifi 1 director,	o Be	examiner? 1 ✓ Yes 2 No	11 21 -11	atient 2 ER	R/Outpatient	3 DOA Other	Nursing H	ome 5 R	esidence 6 🗸 Ot	ther: Scene
of Vital Records, ling Physician: The law requir After this certificate has been s funeral director, page 2 should I	-	27. Manner of Death	28a, Date of FOUND:	Injury 28	Bb. Time of Inj		Su	. Describe ho bject shot	w injury occurred	
ision Attendin r death. rector: A	[ 흝	1 Natural 5 Pend 2 Accident Inves	Dec 21, 20	08   10	OUND: 000 hrs	1 Yes 2 🗸	No	•		
Division tal or Attenditurs after death.  "al Director: △	🚆	3 ✓ Suicide 6 Coul	d not be 28e. Place o			, factory, office building, et		or Town Sta	te)	Rural Route Number, City
Divi	Certification:	4 Homicide		sland on Pot			172			lill, Brunswick, MD
Division of Vital Records, P.O. Box 68760 to the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Finneral Director: After this certificate has been signed by the attending physompleady filled in by the funeral director, page 2 should be detached for use as the b		29a. Certifier 1 Certifying PI (Check only one) 2 Medical Exa	nysician: To the best o	f my knowledge, examination and/	death occurre for investigation	ed at the time, date and plann, in my opinion, death oc	ace, and due ccurred at the	e to the cause e time, date ar	(s) and manner as s nd place, and due to	stated. o the cause(s)
Divis  To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical		and manner stat	ed.		29c. License number			29d. Date signed (	
	2	29b. Signature and title of certifie	11 m			O.C.M.E.			December 22,	, 2008
	[	19. Um Bra	214,1110	of dooth (It 00	32)					
-		30. Name and address of person Melissa Brassell, MD	Assistant Medi			enn Street, Baltimor	re, MD 21	201		
	tate		32 Re	strar's Signature						
	strai		6 2008	was to		ander				

DHMH 17 Rev 1/2001 OCME 2006

Examiner Division or Vital Records, P.O. Box 68760,

The law requires that the death certificate be executed burial-tran and physician the nse for ed by the a detached f signed by the sign of the sign page 2 Physiclan: this funeral Hospital or Attending hours after deat by filled in

**Funeral** 

Director

r 28a-f show notified at

filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or any Injury or other traumatic event, the Medical Examiner must be r

Physician

/Medical

29a. Certifier

To the Fi	edic	one) and manner stated.	estigation, in my opinion, death occurred at the t	ime, date and place, and due to the cause(s)
imos	Ž	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
		Jahndor /g/2 ter 20	H0055927	December 24 2008
5		30. Name and address of person who completed cause of death (Item 23a) (Type, P		1 1 . 1
		Splvador Schoster, 300/ His	pital Drive Co	every Manyland
Sta	ite	31. Date filed (Month, Day, Year) 32. Registrar's Signature		//
Registi	ar	DEC 2 6 2008 Server &	and it	
Rev 1/2	001			

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death December 19, 2008 **Physician** Joyner 1:11a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Clinton order 1 Year | If Under 24 Hrs. Southern Maryland Hospital 8. Date of Birth
July27, 1931 last birthday) 9. Birthplace (State or Foreign **Funeral** Months Min. 1 □ M 2 😡 F 77 241 48 7434 N. Carolina Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinat must be notified 1□Yes 2□No Director MD Prince George's Clinton 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 7715 Castle Rock Drive 20735 US Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: ð Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Private 8th Department of Health and Mental Hygic Important: If them 27 is marked other 1 any injury or other teams. Retail Sales 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Unknown Alberta Alston 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ann G. Clark/daughter 7715 Castle Rock Drive Clinton, MD 20735 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Riverdale Crematory 12-27-08 Riverdale, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Briscoe-Tonic Funeral Home 2294 Old Washington Road Waldorf, MD2060 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Vhyocardia disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions Dilie to Car as a consequence of Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last be executed and burial-tran Due to (or as a consequence of) physician Physician/Medical requires that the death certificate the as attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) the 9 | Ilnknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page certificate 2 No 1 Yes 2 100 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 🗌 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral c 28a. Date of Injury (Month, Day, Year) 27. Manuer of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Box 68760 P.0. Division of Vital Records,

State

DHMH 17 Rev 1/2001

Registrar

completely

Medical

(Check only one

29b. Signature and title of certifi

Richard PALMER

31. Date filed (Month, Day, Year)

DEC 2

32. Registrar's Signature

South em avenue SE

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1328

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

00055120

inte 310 Woshington DC

29d. Date signed (Month, Day, Year)

12-19-2005

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - State Of Ma State Registrar	aryland / Depa <i>Cel</i>	artment of H rtificate of L		, 0	iene 9. No. 2 () () 8	43050
	Dhusisi		Decedent's Name (First, Middle, Last)				Date of Death     Month	1	3. Time of Death
	Physici /Medic		Vera A. Jay				December	28, 2008	5:50 P.M
Wallan	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death		4c. County of Dea	
-			Charlotte House		Boonsbo			Washingt	on
	Funeral			e (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 12/23/1	Year) 9. Bir	thplace (State or Foreign ountry)
	Director		190-30-2971 1□ M 2√ F 10	04 Yrs.			12/23/1	904 Peni	nsylvania
	and		10a. State 10b. County	10c. City, Town or Lo	ocation				10d. Inside City Limits
	Maryl f sho	jor	Do Fulton	II	1 _1				17ŽTYes 2∐ No
	the 28a	Director	Pa. Fulton  10e. Street and Number	Warford	10f. Zip Code		10	g. Citizen of What Co	11
	3a or		2486 McKees Gap Road		17267				-
	ms 2	Funeral	11. Marital Status 12. Was Decedent	Ever in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Spe	ecify Yes or No-	United S	
9	or ite		Armed Forces?  1 □ Never Married 2 □ Married 1 □ Yes 2 ☑ 1	No			Rican, etc.)	Black, Whit	e, etc.
03	ral", c	by	3 ☑ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:		1 ☐ Yes 2 🃉 No	Specify:		Specify: W	nite
21215-0036	be filed within 72 hours after death with the Maryland that Hygiene. Id other than "natural", or items 23a or 28a-f show event, if a Model Evaninar must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occupa kind of work done o	ation	ina 1	6b. Kind of Business	/Industry
2	ithin ne.	np	Elementary/Secondary (0-12)  College (1-4or 5	i+) life.	DO NOT use retired,	)	, ig		
	lygier	၀		homen	naker			own home	
anc	be file	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name		laiden Surname)	
ž	should and Mer s marke umatic	၉	Alvah T. Foster			Belle A			
Maryland	d 2 st th an 7 Is r traur		19a. Informant's Name/Relationship (Type. Print)  Millie Steinke / daughter					City or Town, State,	Zip Code)
	1 and Health em 27 ther tu		20a. Method of Disposition		S. Foster			PA 17211 Oc. Location - City or	Town State
jo	Pages nent of unt: If its ury or o		X Burial 2 ☐ Cremation 3 ☐ Removal from State	20b. Place of Dispo		i	1		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, if a Medical Examinat must be notified at once.		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service License	Fairview		101/03	/2009   A	rtemas, PA	1.
Ba	permit. Departn Importa any injt			MO1222 10	06 East Cl	nurch St.	ney & ва , Freder	sford Functick, MD 21	eral Home 1701
т			23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lir	the death. Do not ent	er the mode of dying	g, such as cardiac o	or respiratory arre	st,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	mendoa				i i	Onset and Death
	/Medical		resulting in death)  Due to (or as	a consequence of):				7	
	Examiner	_	Sequentially list conditions, b.						
	sit sed	ine	Sequentially list conditions, if any, leading to immediate cause. First Indentificate Cause for Indentification Cause (Disease or injury	a consequence of);					
Ĭ.	and and Il-tran	Examiner	that initiated events c.	a consequence of):					
68760, 🕏	tificate be executed g physician and as the burial-transit								
289	tificate ig phy as the	edical	a			-			
Вох		[ ≥	F FEMALE: 23c. If yes, outcome 23c. If yes, outcome					23d. Date of del	iverv
m .	The law requires that the death cerate has been signed by the attendinage 2 should be detached for use	Physician/N	in the past 12 months?  1 □ Ves 259No 4 □ Pregnant at		Dectopic pregnancy Other (specify)			Month	Day Year
P. O.	at the de I by the stached	hys	9 Unknown						
	gned ge det	by P	Part II. Other significant conditions contributing to death but	ut not resulting in the ur	nderlying cause give	n in Part I.	23e. Did toba	acco use contribute to	the cause of death?
g	w requires s been signi should be						1 □ Yes	s 2 □ No 3 □ Pr	obably 4 🔁 Jnknown
Records,	e 2 sh	Completed					24a. Was an autopsy	24b. Were au	stopsy findings available completion of cause of
_		50					perform	ed?   death?	2 No
Vital	sician: The certificate I rector, page	Be (	25. Was case referred to medical examiner?			26. Place of Death			
-	di is i	2	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatie	nt 2 ER/Outpatien	nt 3 DOA Othe	r: 4 Nursing Hor	me 5 Residen	nce 6 Sother (Spe	city) AL (+
Ē	Attending Physician: r death. ector: After this certific. by the funeral director,	ü	27. Manner of Death  1 Natural 5 Pending  28a. Date of Injuity (Month, Day)	ry 28b. Time of v, Year) Injury	Work'	?	28d. Describe how	v injury occurred	
S	ttend death tor: the t	cat	Accident investigation  3 Suicide 6 Could not be			′es 2□No			
Division of	or A after Direc	Certification:	4 Homicide determined 206. Place of Influence building, etc.	ury - At home, farm, stre c. (Specify)	еет, тастогу, опісе	1	City or Town,	eet and Number or Ru State)	ıral Route Number,
_	spital ours neral filled		29a. Certifier 1 Certifying Physician: To the best of	of my knowledge, deatl	occurred at the tim	ne date and place	and due to the car	use(e) and manner as	etated
	o the Hospital or Attending Prithin 24 hours after death.  o the Funeral Director: After the ompletely filled in by the funeral	Medical	(Check only one) 2 Medical Examiner: On the basis of and manner sta	examination and/or in	vestigation, in my op	pinion, death occurr	ed at the time, dat	te and place, and due	to the cause(s)
	To the I within 2 To the I complet	Σ	29b. Signature and title of certifier		29c. License			d. Date signed (Monti	
					07.5	5352	/	12-39-	2008
	10		30. Name and address of person who completed cause of de Dr. Kahlid Waseem / 1126	eath (Item 23a) (Type, I Opal Ct. F	Print)		740	<del></del>	
	Stat	e	31. Date filed (Month, Day, Year) 32. Registra	ar's Signature	-46CEBCOWI	21	, 10		
	Registra	ır	JAN 1 2 2009 Server	ar's Signature					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 12-29-2008 3:15 P <sup>™</sup> Mary Ann Kerins 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Keedysville 19925 Marble Quarry Road Washington if Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 1 □ M 2 🔀 F 58 Months Days Hours Min 182**-**38-9867 March 4,1950 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Md. Washington Keedysville 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19925 Marble Quarry Rd. U.S.A11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Counselor Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Henry Kerins Mary Louise Hickey 19a. Informant's Name/Relationship (Type. Print) Gillian M. Craig (Friend) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19925 Marble Quarry Rd. Keedysville, Md. 21756 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Smithsburg, Md. 4 □ Pronation 5 □ Other (Specify) Smithsburg Crematory 22. Name and Address of Facility re of Funeral Service Licensee MO1414 J.L. Davis Funeral Home 12525 Bradbury Ave. Smithsburg, Md. 21783 Part 1. Inter the disease, or complications that caused the shock, or hear failure. List only one cause on each line disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 225 pinton a-ces Due to (or as a consequence of): 12411 Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 01-119000 Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day Month Year Pregnant at time of death 5 ☐ Other (specify) 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?

**Physician** /Medical Examiner Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f shov

the

filed within 72 hours after death with

12 should be filed within; th and Mental Hygiene. 7 is marked other than "r

Pages 1 and 2 ment of Health a

permit, Pages Department of Important: If it any injury or o

Baltimore, Maryland 21215-0036

Box 68760,

Ö

₫.

Division of Vital Records,

Director

Funeral

þ

Completed

Be

ဂ

item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the "Modeal Examinating the notified at

and I-trar burial-Physician/Medical the by Completed Be

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. attending physician for use as the buria signed by the d cate has page 2 s certificate this After thi funeral of within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

					**		-	1 □ Yes 2 🖪	Mo 3 Probably 4 Unknown
							-	24a. Was an autopsy performed? 1 □Yes 2 □ No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
25. Was case referred to examiner?	to medical					26. Place of D	eath (0	Check only one)	
1 Yes 2 Mo		Hospital: 1 ☐ I	npatient 2	] ER/Outpatient	3 □ DOA	Other: 4 \( \sum \) Nursing	Home	Sa Residence 6	Other (Specify)
2 Accident	☐ Pending investigation	-	of Injury h, Day, Year)	28b. Time of Injury	280 M	. Injury at Work? 1 □Yes 2 □No	286	d. Describe how injury	occurred
3 ☐ Suicide 6 4 ☐ Homicide	Could not be determined	28e. Place buildi	of Injury - At h ng, etc. <i>(Speci</i>	ome, farm, stree	et, factory, o	ffice	28f	Location (Street and City or Town, State)	Number or Rural Route Number,
29a. Certifier 1 (Check only one) 2	Certifying Ph	iner: On the b	best of my kno	owledge, death ation and/or inve	occurred at estigation, ir	the time, date and pla my opinion, death of	ce, and	d due to the cause(s) at the time, date and	and manner as stated. place, and due to the cause(s)

014625

29d. Date signed (Month, Day, Year)

30,200

State Registrar

Medical Certification: To

29b. Signature and title of certifier

5 01 32. Registrar's Signature and

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

		For State Registrar	State of	Marylar		artmen				lental Hyg	iene	0.8	430	152
Physic		Decedent's Name (First, Middle, Le Sang Up Kim	ast)							2. Date of Dea Month	Day	Year	3. Time of 11:50	
/Medi Examii		4a. Facility Name (If not institution, gi		,			Town, or	Location		December	4c. Count Montgo	y of Death		
Funeral Director		218-77-6195	Sex 1□M 2⊠F	7. Ag <i>e (In yr</i> s. 94	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Birth (Month, Day March 07,	Year) 1914	9. Birthp Cour Kor		or Foreign
h the Maryland ir 28a-f show	Director	Usual Residence of Decedent  10a. State 10b. County  Maryland Montgome:  10e. Street and Number	су		ty, Town or Lo		Codo				On Citizen of			ity Limits 2蒼No
iore, Maryland 21215-0036 ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If them 27 is marked other than "natural", or items 23a or 28a-f show of them 27 is marked other than "natural", or items 28a for 28a-f show or other traumatic event, the Madical Examinar must be notified at	by Funeral	13921 Bailiwick Te: 11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedarmed Ford 1Yes If Yes, Given Year or Da	ces? 2 🖸 No e		10f. Zip  2087  Was Deced f Yes, spec	4 lent of Hi cify Cuba	spanic Ori n, Mexicar Specify:		ecity Yes or No- Rican, etc.)		ce - Americ	ean Indian, etc.	
21215-( 21215-	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12) Unknown	ducation ade completed) College (1-	4or 5+)	life. I	dent's Usua kind of wor DO NOT us nemaker	rk done a se retired	lurina mos	t of workii	ng	16b. Kind of B		dustry	
Maryland 212. Id 2 should be filed within th and Mental Hygiene. It is marked other than traumatic event, It a M	To Be C	17. Father's Name (First, Middle, Las Man-Jong Kim						Un	obtair					
Baltimore, Mar permit. Pages 1 and 2 sh Department of Health an Important: If fiem 27 is n any injury or other traun once.		19a. Informant's Name/Relationship  Mr.Young-Su Park/ 5  20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐	SonRemoval from S	late	1392 Place of Dispo cemetery, cren	1. Bail sition (Nam natory or of	iwick ne of ther place	Terra	ace;Ge	. 1	MD 20874 20c. Location	- City or To	wn, State	
Baltimore, permit. Pages 1 ar Department of Hee Important: If item any injury or othe once.		4 □ Donation 5 □ Other (Species 21. Signature of Funeral Service Lice		Lak ext		. Name and	d Addres	s of Facilit	Hine	s-Rinaldi ue: Silve		Home,	Inc.	
Physician / Medical Examiner physician and the prival-transit	ical Examiner	23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	one cause on each a.  Direct (// b.  Due to (o	used the deat ch line.	uence of):	a lew				r respiratory arro	est,		Approximate Interval Bet Onset and I	ween
O. Box 68 he death certific the attending p	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ■ No 9 □ Unknown		rth 2 ☐ Feta ant at time of o	ldeath 3□	Ectopic pr Other (spe						te of delive		Year
cords, P. w requires that t s been signed by should be deta	by	Part II. Other significant conditions	contributing to dea	ath but not resi	ulting in the ur	iderlying ca	use give	n in Part I.		23e. Did tob	acco use cont		e cause of c ably 4 🗍 l	
	Completed								<del></del>	24a. Was ar autops perform 1 □ Yes 2	red2	Were autor prior to cor death? 1 ∐Yes	osy findings inpletion of c	available ause of
sion of Vita ending Physician: aath. or: After this certific he funeral director, i	ation: To Be	25. Was case referred to medical examiner?  12 Yes 2 No  27. Manner of Death 1 Natural 5 Pending investigatio	28a. Date of (Month)		ER/Outpatien 28b. Time of Injury		Bc. Injury Work	r: 4 🗆 Nu	rsing Hon	(Check only one ne 5 Reside 8d. Describe ho	nce 6 Oth		/)	
Division o  To the Hospital or Attending PP within 24 hours after death.  To the Funeral Director: After it completely illed in by the funeral	Certification:	3 Suicide 6 Could not b	building	g, etc. (Specif					4	8f. Location <i>(Sti</i> City or Town	, State)			nber,
the Hosp thin 24 ho the Fune mpletely f	Medical	29a. Certifier (Check only one)  1 Certifying Price Medical Example (Check only one)	nysiclan: To the bas niner: On the bas and manne	sis of examina	wledge, death	estigation,	in my op	pinion, dea	d place, a th occurre	ed at the time, da	ite and place,	and due to	the cause(s	5)
To To COI		29b. Signature and title of certified	le fer	- 1	10		License		7		CCCM:	d (Month, L	12 Z	008
		30. Name and address of person who	1. Geor	ge M	23a) (Type, F	990	1 1	1ed	1100	e Cen	Lenox	. Roc	hilke	MD
Sta Registra		31. Date filed (Month, Dáy, Year) DEC 2 4 20(		dstrar's Signa	ture	E.								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Betty Jean Kenel December 20, 2008 9:50A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 9. Birthplace (S Country) Casey House Rockville
If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) State or Foreign 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 💢 F Months Days Hours Min. 316-69-0722 Michigan 1920 December 6. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No Maryland Montgomery Silver Spring 10e. Street and Number 10g. Citizen of What Country? 15013 Butterchurn Ln Funeral 20905 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 No Specify. \$ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Saginaw City College (1-4or 5+) Secretary Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be မ Philip John Markey Ruth Ann Morden 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dr. Francis C. Kenel/Husband 15013 Butterchurn Ln, Silver Spring, MD 20905 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Crematory Dec 30, 2008 Brentwood, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home 111800 New Hampshire Ave, Silver Spring, MD 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediale Cause (Final disease or condition resulting in death) Sepsis Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Examine Due to (or as a consequence of): Due to (or as a consequence of): Physician/Medical JF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 X No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ≥ GI Bleed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 XNo 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2X No Other: 4 In Nursing Home 5 Residence 6 Cother (Specify) Hospice 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural

P.O. Box 68760 Division of Vital Records, Director

72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

d 2 should be filed within 72 hours after death with the Marylan th and Mental Hygiene.
7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Eventher mast to refilted at

1 and 2 s Health ar

permit. Pages 1 and 1 Department of Health Important: If item 27 any Injury or other tra once.

Physician

/Medical

Examiner attending physician and for use as the burial-tran signed by the ad be detached f icate has been sig ; page 2 should b Hospital or Attending Physician: The certificate this certific al director, Certification: To After t 5 ☐ Pending investigation death. ithin 24 hours after death.

the Funeral Director: A smpletely filled in by the fu 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Koudetchou, ms Jocetyne D0063748

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year) 2 4 2008 DEC

Jocelyne Koudtchou,

MD 6001 Muncaster Mill Rd, Rockville, MD 20855 32 Registrar's Signature

December 23, 2008

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Lillian Mae Kenney 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner sb Wicomico If Under 24 H Date of Birth (Month, Day Birthplace (State or Foreign Country) **Funeral** Min. Days Hours 1 □ M 2 🔀 F 214-30-7975 01/17/1913 95 Maryland Director Usual Residence of Decedent 10c. City, Town or Location filed within 72 hours after death with the Maryland 10a. State 10b. County 10d. Inside City Limits ms 23a or 28a-f show must be notified at 1 XYes 2 No Maryland Wicomico Salisbury Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 200 Civic Ave. 21801 USA 'natural", or items 23a by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. Injury or other traumatic event, the Medical Examiner 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2**X** No Specify: Specify: white 3 X Widowed 4 □ Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) sales clerk 10 retail 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be Albert H. Jones Eva Mae Kelly 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley K. Johnson/daughter 5829 Brandywood Lane, Salisbury, MD 21801 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or ot Wicomico Memorial 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 12/26/08 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) Park 21. Signature of Funeral Service Licensee 22, Name and Address of Facility
Holloway Funeral Home Professional Association Charaganal 501 Snow Hill Rd., Salisbury, MD 21804 CESP 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or at a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 ♣No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No page 2 1⊟ Yes 2 No To the Hospital or Attending Physician: funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 🔲 Inpatient 3□ DOA 2 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 ANatural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) H. Robins, M.D.
Year) 32. Registrar's Signature 2000 illiam IVIC 31. Date filed (Month, Day, Year) State DEC 2 9 2008 Registrar

			1- State of Maryland / Dep Registrar Ce	artment of Health and M <i>rtificate of Death</i>	ental Hygiei Reg.	2008	3 43056
	Dharia		1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day V.	3. Time of Death
	Physici /Medio		Woodrow Lawrence Lynn		December	Day Yea 20, 2008	
	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of De	eath
			Holy Cross Hospital	Silver Spring		Montgon	
	Funeral		5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday,	Months   Days   Hours   Min.	8. Date of Birth (Month, Day, Yea	ar) 9. B	irthplace (State or Foreign Country)
	Director		211-01-7564 94 Fis.  Usual Residence of Decedent		March 7,	1914 F1	orida
	/land		10a. State 10b. County 10c. City, Town or Lo	ocation			10d. Inside City Limits
	Mary 1-f sh	tor	Florida Escambia Pensac	012			1 □ Ye <i>s</i> 2 <b>X</b> No
	h the	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What (	Country?
	th wit		604 West Blount St	32501	II	SA	
	ems	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto F		14. Race - An	nerican Indian,
92	after or it		1 Never Married 2 Married 1 Tyes 2 No	1 □Yes 2 x No Specify:	ncari, etc.)	Black, Wh	ite, etc.
Ö	be filed within 72 hours after death with the Marylan nta! Hygiene. ed other than "natural", or items 23a or 28a-f show event, I'm Mydical Evan it set must be notified at	d by	3 Wildowed 4 Divorced Year or Dates: WWII			Specify:	White
5	n 72 "nat	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of workin DO NOT use retired)	g j	Kind of Busines	,
12	withii iene. than	mc	Elementary/Secondary (0-12) College (1-4or 5+)	vil Engineer		ited Sta	
0	illed Hygi other ent,	BeC	17. Father's Name (First, Middle, Last)	18. Mother's Name		vernment en Surname)	•
Maryland 21215-0036	should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Mydical Evan item roust be notified at	To B	Sweetsey Eugene Lynn	Ethel N	McCain	,	
ary	shou and N s mai	-		ng Address (Street and Number or Rural		y or Town, State,	, Zip Code)
	and 2		Marsha Youngblood/Daughter 8207	Grubb Rd, Apt. #10	03. Silve	r Sprine	MD 20910
Se	. Pages 1 and 2 should be treent of Health and Ment: tant: If item 27 is marked lury or other traumatic e		20a. Method of Disposition 20b. Place of Dispo			Location - City o	
Ĕ	Pagament ant: I		M Durial 2 Colemator 3 & Hemoval from State	National Cem Dec	30. 2008	Pensac	ola. FL
Baltimore,	permit. Page Department Important: It any injury o		21. Signature of Funeral Service Licensee 22	2. Name and Address of Facility Hine	es-Rinald:	i Funera	1 Home
п	20 E 8 9		Nancy A. Tercen Ve 1	1800 New Hampshire	Ave, Sil		
			23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac or	respiratory arrest,		Approximate Interval Between
	Physician		Immediate Duse (Final disease or condition Cardio Pulmona				Onset and Death Instant
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):	,			
	Lxammer	_	Sequentially list conditions, b. Con estive Hea	rt Failure			
,	ted 1sit	Examiner	dury, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events				1
<u> </u>	execu n and al-trai	xar	that initiated events resulting in death) Last C				
8/60	tificate be executed g physician and as the burial-transit	al					
Q	ifficat g phy as the	edical	u.				
×	se din		IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	3		23d. Date of de	eliverv
	deat e atte	Physician/N	in the past 12 months? 1 Live birth 2 Fetal death 3 L	Ectopic pregnancy Other (specify)		Month	Day Year
т. Э	at the by th tache	hys	9 Unknown				
ທົ	es the		Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause given in Part I.	23e. Did tobacco	use contribute	to the cause of death?
ecords	equir	ed	Dementia		1 ☐ Yes	2 □ No 3 □ F	Probably 4 ☐ Unknown
ပ္သ	The law requires that the death ate has been signed by the atter page 2 should be detached for u	Completed by	Hypertension		24a. Was an autopsy	24b. Were a	utopsy findings available completion of cause of
=	: The	် ပ	Diabetes Mellitus Type II		performed?	death?	s 2 No
Z Z	ician Sertifii ector,	Be	25. Was case referred to medical examiner?	26. Place of Death			
5	Physical this call direction	၉	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien		e 5 🗆 Residence		ecify)
	ding After funer	- L	27. Manner of Death  1X☐ Natural 5 ☐ Pending (Month, Day, Year)  28b. Time of Injury (Month, Day, Year)	Work?	3d. Describe how inj	ury occurred	
VISION	deatl deatl ctor: y the	lical	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, str	M   1   Yes 2   No	24 Looption (Otro-14)		
2	after Dire	Certification:	4 Homicide determined building, etc. (Specify)	set, factory, office	City or Town, Sta	and Number or H ite)	Rural Route Number,
	To the Hospital or Attending Physician: The law requires that the de within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death	n occurred at the time, date and place, ar	nd due to the cause	(s) and manner a	as stated.
	he Ho in 24 he Fl	edical	(Check only one) Additional Examiner: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occurred	d at the time, date a	nd place, and du	e to the cause(s)
	Vith Con	Ž	29b. Signature and title of certifier	29c. License number		ate signed (Mon	
	17/		Can.	D28656	De	ecember	22, 2008
	1		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)			
			Rayi Passi, MD 15225 Shady Grove Ro	d, #208, Rockville,	MD 20850	)	
	Stat Registra		31. Date filed (Month, Day, Year)  DEC 2 4 2008  Registrar's Signature	elli s			
	riegistic		DEO WIE COOL KIENER SON				

			for State Registrar	State of	f Maryland / De	oartment of I ertificate of		Mental Hy	giene Reg. No	008	43057
			Negistrar     Necedent's Name (First, Mid	fdle, Last)			Douti	2. Date of De		000	3. Time of Death
	Physici		Doris Levin					Month Decemb	er 20	Year 2008	5:45 P M
and in	/Medic Examir		4a. Facility Name (If not institut	ion, give street and nun	nber)	4b. City, Town, o	or Location of Dea		T	ounty of Death	1_3.43
mar of the			2901 South Lei	sure_World	B1vd#312	Silver			Mo	ntgomer	У
	Funeral		5. Social Security Number		7. Age (In yrs. last birthda	y) If Under 1 Year Months Days	If Under 24 Hr Hours Mir	. (Month, D	rth a <i>y, Year)</i>		place (State or Foreign
	Director		228-26-7882 Usual Residence of Decedent	1,2,111 -22	80 Yrs.			08/28	/1928	F1c	orida
	land ow		10a. State 10b. Coun	ty	10c. City, Town or	Location				1	0d. Inside City Limits
	r 28a-f show	ţoţ	MD Monts	gomery	Silver S	nrina					1  Yes 2□No
	death with the Maryland ms 23a or 28a-f show	Funeral Director	10e. Street and Number	Some Ly	DIIVEL	10f. Zip Code			10g. Citize	en of What Cour	ntry?
	th wit	ral	2901 South Lei	isure World	B1vd#312	2090	6		USA		
	items items	nue	11. Marital Status	12. Was Dece Armed For		B. Was Decedent of I	Hispanic Origin? (	Specify Yes or Norto Rican, etc.)	0- 14	Race - Americ Black, White,	
36	be filed within 72 hours after death with that Hygiene. d other than "natural", or items 23a or event, I'ra Madical Examinat must be.	by F	1 ☐ Never Married 2 【 Ma 3 ☐ Widowed 4 ☐ Divorce	If Yes, Giv	<sup>2</sup> ♥No	1 □Yes 2X No				Specify:	
21215-0036	"natural", or	ed k		ent's Education		cedent's Usual Occu	nation		16h Kino	What of Business/Inc	nite
215	iin 72 n "nat	Completed	(Specify only high Elementary/Secondary (0-12)	nest grade completed)	(Gi	ve kind of work done . DO NOT use retire	during most of wo	orking	l ob. Killo	or Business/inc	austry
212	d within giene. er than "	E O	11	) College (1-		ness Owne	r		R	etail	
pu	be file Ital Hy d othe event,	Be	17. Father's Name (First, Middle	e, Last)			18. Mother's Na	me (First, Middle	, Maiden Si	urname)	
yla	should be filed within nd Mental Hygiene. marked other than umatic event, the Mental than the matic event, the Mental than the matic event, the Mental than th	၉	Moses Mensh	. <u></u> .			Hannah	Cohen			
Maryland	2 sho n and l is ma rauma		19a. Informant's Name/Relation	nship (Type. Print)	<sup>19b</sup> 2 <sup>Mg</sup>	iling Address <i>(Street</i> 01 South	and Number or F Leisure	Rural Route Numb ${ t Norld}  { t Bl}$	er, City or $\mathbb{T}$	Town, State, Zip	Code)
	1 and Healtl		Sumner Levin 20a. Method of Disposition	husband	#3	12		Sil	ver Sj	pring MI	20906
Baltimore,	ages nt of f		1 ☑ Burial 2 ☐ Cremation		State Cemetery, c	position (Name of ematory or other pla	ce)	Date	20c. Loca	ation - City or To	wn, State
Œ	nit. Partme		4 ☐ Donation 5 ☐ Other 21. Signature of Funeral Service	· · · · · · · · · · · · · · · · · · ·	Mt. Lebr	on Cemete 22. Name and Addre		23/2008	Adelp	hi, Mar	yland
Ba	permit. Pages 1 and 2 should be Department of Health and Mente Important: If item 27 is marked any injury or other traumatic ev once.		21. digitature of 1 differ at Service	e Licensen	2/1/-	.091 Rockv	Edwa	ard Sage	1 Fund	eral Di	rection
			23a. Part 1. Enter the disease,	or complications that ca	aused the death. Do not e	nter the mode of dyi	ng, such as cardia	e ROCKV	rrest.	MD 208 <u>5</u>	Approximate Interval Between
	Physician		Immediate Cause (Final	st only one cause on ea	ach line.						Onset and Death
	/Medical		disease or condition resulting in death)		eatic Carcin or as a consequence of):	ioma with	Liver Me	tastases	Ü		2yrs.
	Examiner		Poguantially list conditions	h							
0	pe #	iner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury	Date to (c	or as a consequence of):					-	
D	and -trans	Examiner	that initiated events resulting in death) Last	c	or as a consequence of):						
8760,	cate be executed physician and the burial-transit	ᄪ		Due to (c	or as a consequence of).						
687		edical		d							
Вох	eath certific attending p for use as	Ž	IF FEMALE: 23b. Was decedent pregnant		come of <u>pr</u> egnancy	_			23	d. Date of delive	erv
	death e atte	icia	in the past 12 months? 1 □ Yes 2 ☒No	4 ☐ Pregn	ant at time of death	B ☐ Ectopic pregnand □ Other (specify) _	cy				Day Year
P.0	The law requires that the death certifiate has been signed by the attending age 2 should be detached for use as	Physician/Me	9 🗆 Unknown	9 ☐ Unkno	own						
	res that signed I be det	by F	Part II. Other significant condi	tions contributing to dea	ath but not resulting in the	underlying cause giv	en in Part I.	23e. Did 1	obacco use	contribute to the	e cause of death?
ord	w requir s been s should	ted				<del></del>		10	Yes 2X	No 3 ☐ Prob	ably 4 Unknown
Records,	e 2 sh	Completed						24a. Was	osv I	24b. Were autop prior to cor	psy findings available mpletion of cause of
	ysician: The iis certificate hi director, page	Š						perfo 1 ☐ Yes	rmed? 2 X No	death?	2 <b>X</b> 1No
of Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medic examiner?	Hospital		Oth		ath (Check only o			
of	<b>₹</b> € E	ا يا	1 ☐ Yes 2 💢 No 27. Manner of Death	1 ☐ Ir	npatient 2 ER/Outpat		T I I I I I I I I I I I I I I I I I I I	Home 5 N Resi			)
Division	ding Phy th. : After thi ; funeral	ţi	1 X Natural 5 ☐ Pend		n, Day, Year) Injury	Wor	k?  Yes 2□No	26d. Describe	now injury o	ccurred	
Visi	I or Attendi after death. Director: A	ifica	3 ☐ Suicide 6 ☐ Could	d not be 28e, Place of	of Injury - At home, farm, s			28f. Location (	Street and f	Number or Rura	l Route Number,
Ö	s afte	Certification: To	4 ☐ Homicide deter	buildin	g, etc. (Specify)			City or To	wn, State)		
	Hospital or Attending 24 hours after death. Funeral Director: After itely filled in by the fune		29a. Certifier 1 Certify	ring Physician: To the la	best of my knowledge, de sis of examination and/or	ath occurred at the ti	me, date and plac	e, and due to the	cause(s) as	nd manner as si	tated.
	the the the	Medical	onej	and mann	er stated.			arred at the time,			
	S S S S S S S S S S S S S S S S S S S	-	29b. Signature and title of certifi	m/	>	29c. Licens			29d. Date s	signed (Month, I	Jay, Year)
	12		2 Dinis 1	110	-f.dN. (b	D239	958	I	Decemb	er 22,	2008
			30. Name and address of perso	·	, , , , ,		בנת ג.		100	20006	
	Sta	te	31. Date filed (Month, Day, Yea.	r) 3505 N	th. Leisure	MOLTG RIA	u.,Sllve	r Spring	MD	20906	
	Registr	ar	DEC 24	2008	in St. April	Will .					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Vaar Fatt Mon Lee 22. 1:56 p /Medical December 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 6 Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days XX M 2 F Yrs Director 578-38-8244 84 10, 1924 China Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f showevent, the Medical Examination that be notified at Director 1 ☐ Yes 2 No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2417 Lillian Drive 20902 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2☐ Married 1 ∰Yes 2 □ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 □Yes 2x No Š Specify: 3 Widowed 4 Divorced 1943-46 Asian Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electrical Engineer U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Wai Cho Lee 2 Ma Cheng Yau 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health an Important: If item 27 is any Injury or other trau Mary Lee/Wife 2417 Lillian Drive, Silver Spring, MD 20902 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Dec. 26, George Washington Cemetery 2008 Adelphi, Maryland 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licensee 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Acute Myocardial Infarction disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Coronary Artery Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: or Attending Physician: The law requires that the death certificate be executed Exam physician and s the burial-trans Hypertension Due to (or as a consequence of): Box 68760, Physician/Medical Diabetes attending pl for use as t IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 

Ectopic pregnancy Month Year 5 Other (specify) Division of Vital Records, P.O. certificate has been signed by the a rector, page 2 should be detached it ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🎦 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2X No 1 □Yes 2 🗆 No 1 □ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 □ Yes 2√F2tNo Certification: To 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred s after dea...ral Director; Aft 1X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral Completely filled filled Hospital Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Daniel Sherk, MD 1500 Forest Glen Road, Silver Spring, MD 20910 31. Date filed (Month, Day, Year) Registrar's Signature State 2 4 2008 DEC Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		For State Registrar  1. Decedent's Name (First, Middle, Last,	State of Maryla	Cer	tificate of L	Death	2, Date of De	Reg. No. 2	008 4305 3. Time of Death
Physicia /Medic		ALBERTA BERNICE	E LEE				DECEMB	ER 22,	2008 1553 M
Examin		4a. Facility Name (If not institution, give: CIVISTA MEDICAL CE  5. Social Security Number  6. Se:	NTER	s. last birthday) Yrs.	4b. City, Town, or  LAPLATA  If Under 1 Year  Months Days		8. Date of Birt	th ly, Year)	RLES  9. Birthplace (State or Foreign Country)
oirector		578–16–3211  Usual Residence of Decedent  10a. State 10b. County	. 69	ity, Town or Lo	cation		DEC. 6	, 1919	MARYLAND  10d. Inside City Limits
a-f sho	ctor	MD CHARLES		RYANS R					1 ZYes 2 □ No
a or 28 t be no	I Dire	10e. Street and Number 6981 HEATHER DRIV	E		10f. Zip Code <b>20616</b>				What Country? STATES
iten 27 is marked other tran "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral Director		12. Was Decedent Ever in Named Forces?  1 ☐ Yes 2 No If Yes, Give Year or Dates:		Uvas Decedent of His fYes, specify Cubar □Yes 27 No	spanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)		ace - American Indian, ack, White, etc.
an "natura Medical E	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed) College (1-4or 5+)	16a. Deced (Give life. L	ent's Usual Occupa kind of work done d OO NOT use retired,	ation luring most of wor )			Business/Industry
ther th		12 17. Father's Name (First, Middle, Last)		ELEVA	TOR OPERA	TOR 18. Mother's Nan			TOF DISTRICT COLL
arked o	To Be	CHARLES ATLEE			ı	MABEL 1	BUTLER A	TLEE	
27 Is m		19a. Informant's Name/Relationship (Ty JOHN LEE/HUSBAND	pe. Print)		g Address <i>(Street a</i> ${\sf X}$ ${\sf 741}$ , ${\sf BR}$				
		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ F	20b.	Place of Dispo cemetery, crer	sition (Name of natory or other place	θ)	Date	20c. Location	- City or Town, State
Important: If any Injury or once.		4 □ Donation 5 □ Other (Specify)  21. Sign → Funeral Stervice Licens	Mi	THODIST					HEAD, MARYLANI , MD 20640
physician and edical sthe burial-transit	edical Examiner	23a. Part1. Enter the disease, or compl shock, or heart failure. List only or immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	quen e pri guence of):	i few t			rrest,	Approximate Interval Between Onset and Death
To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for us⊭ as:	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome pf pregr 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	taldéath 3□	Ectopic pregnancy Other (specify)				ate of delivery Ionth Day Year
en signed b	by	Part II. Other significant conditions co	ntributing to death but not re	sulting in the ur	derlying cause give	en in Part I.	23e. Did t		ntribute to the cause of death? 3 ☐ Probably 4 ☐Unknow
icate has be r, page 2 sh	Completed						1□ Yes	osy rmed? 2 - No	. Were autopsy findings availab prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
nis certi directo	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital: 1 ☐ Inpatient 2	ER/Outpatien	t 3 DOA Othe	ar:	ath <i>(Check only d</i> Iome 5 ☐ Resid	,	ther (Specify)
After th funeral		27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	rat ;? Yes 2 □ No	28d. Describe I	how injury occu	irred
al Director: ed in by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At l building, etc. (Spec	home, farm, str ify)			28f. Location (S City or Tox		ber or Rural Route Number,
etely fills	Medical (	29a. Certifier 1	sician: To the best of my kr iner: On the basis of examir and manner stated.	nowledge, death nation and/or in	occurred at the time vestigation, in my op	ne, date and place pinion, death occu	e, and due to the urred at the time,	cause(s) and n date and place	nanner as stated. e, and due to the cause(s)
To the	Me	29b. Signature and title of certifier	lett in	)	29c License	number OZ 103	31	/	ed (Month, Day, Year)
3		30. Name and address of person who come and address of person who	ompleted cause of death (Ite	0700	ld Line C	tr #302	Walde	orf, MI	20602

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Elsie Mae Looney /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Wicomico Rehab & Nursing Ctr isburg Delisbury 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8 Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex Funeral 1 ☐ M 2 🔀 F Months Days Hours Min. 577-18-8303 Director 03/27/1917 Georgia Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits iral", or items 23a or 28a-f show Examiner must be notified at 1 X Yes 2 □ No Director Wicomico Salisbury Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1833 Mt. Hermon Road 21804 USA "natural", or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 X No Specify: white Specify: þ 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9 housewife domestic Department of Health and Mental Hygi Important: If item 27 Is marked other any Injury or other traumatic event, ti once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Willie Mae Moore B. Terrell McConnell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harvey E. Looney/son 4615 Pheasant Dr., Salisbury, MD 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln Cemetery 12/30/08 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 2 Horroway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 OCFSP MOSCA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of and you Due to (or as a consequence of) physician a the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) the 9☐Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ has been sig 1 ☐ Yes 2 ☐ Ho 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No , page certificate 25. Was case referred to medica Be 26. Place of Death (Check only one) Other: 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death Time of 28b. 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Matural 1 Yes 2 No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: within 24 hours after death

To the Funeral Director: ,
completely filled in by the f

the Maryland

with

death

Pages 1 and 2 should be filed within 72 hours after

Maryland

Baltimore,

[1]

sobins.

29b. Signature and title of certifier

4 ☐ Homicide

(Check only one)

29a, Certifier

cal

State

Registrar

31. Date filed (Month, Day, Year) DEC 2 9 2008

29c. License number

1 Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month. Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

miD.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** LEWIS GRETCHEN 2008 18:20 29 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cumberland Allegany WMHS-Memorial Campus If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day Ye Apr 13, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Funera! Year) 1914 Months Days Hours 1 □ M 2 □ 🙀  $^{\gamma}\!\mathsf{MD}$ 213-22-3021 94 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State id other than "natural", or items 23a or 28a-f show event, the Wolfcal Examinar must be nothed at MD Allegany Cumberland 1 ☐ Yes 2 ☐ No Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 21502 USA 730 Furnace Street Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 □ No Maryland 21215-0036 Specify: ģ 3 ☐ Widowed 4 ☐ Divorced white Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) G&G Grocery owner/operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked other any injury or other traumatic event Jack Rodenhauser Blanche Rodenhauser ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 635 Chatas Ct. Lake Mary FL 19a. Informant's Name/Relationship (Type. Print)

James Lewis 32746 son 3altimore, 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Sunset Memorial Park 1/3/2009 Cumberland MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fune I Service VI 22. Name and Address of Facility rail Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cau e (Final disease or condition resulting in death) Physician 10 DAYS SEPSIS /Medical Due to (or as a consequence of): Examiner 10 DAYS b. URINARY TRACT INFECTION Sequentially list conditions, if any loading to in reclaim cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examine Hospital or Attending Physician: The law requires that the death certificate be execute and burial-tran Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 ☐ Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performe certificate 1 ☐Yes 2 ☐No 1 ☐ Yes 2 □No 25. Was case referred to medical examiner? director. Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. n 24 hours after death.

e Funeral Director: A sletely filled in by the fu 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier (Check only one) completely and manner stated. within 2 To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar

State

ND

30. Name and address of person who completed cause of deat (Iteo 23a) (Type, Print)

31. Date filed (Month, Day, Year)

JAN 1 2 2009

14865

#### Amended Items 26 & 29c per Phy. 12/22/2008 Carroll Co., wj1 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) **Physician** A.Miller 12 2008 5:35 РМ Ruth /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Carroll Westminster Dove House 8. Date of Birth (Month, Day, Year 2/6/1922 9. Birthplace (State or Foreign Country) PA 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** Days Months 1 M 2 XF 86 Yrs Director 183-18-6512 death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County ms 23a or 28a-f show must be notified at 1X Yes 2 □ No Littlestown PA Adams **Funeral Director** 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number USA 17340 10 E. Lakeview Dr. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Inforciant: if item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner muone. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married white 1 ☐ Yes 2 X No Baltimore, Maryland 21215-0036 Specify: Specify. Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clothing Manufacturer 11 Seamstress 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John R. Caldwell Grace M. Ensor ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Littlestown, PA 17340 <u> Vicki Morgret / Daughter</u> 444 Prince St. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State Carroll Crematory 12/23/08 Hampstead, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility 17340 Little's F.H. 34 Maple Ave. Littlestown B Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) COPD **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causs (Disease of injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical use as the attending 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) 1 Yes 2 No ed by the a 9 Unknown 9 Unknown signed l 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □ No 24a. Was an page 2 s autopsy perform 1 Yes 2 No To the Hospital or Attending Physician: "within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, p Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 28h Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 1 🔀 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Descritiving Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) 29b. Signature and 29c. License number D67468 29d. Date signed (Month, Day, Year)

WIL

State Registrar

31. Date filed (Month, Day, Year) DEC

30. Name and addre

2008

who completed cause of death (Item 23a) (Type, Print)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Ofelia Noyola-Mo		y State of N - For State	//aryland / [	Departm <i>Certific</i>			Mental Hy		2	00	8 4306
Physicia		Registrar  1. Decedent's Name (First, Middle,Last)		Certino	ate or i		11 - 11	2. Date of Dea	th		1925 hrs.
Medical Examin	ner	Ma Ofelia I	Noyola	Mon	roy		,	Month December			1726 hrs
		4a. Facility Name (if not institution, give stre 218 Woodhill Drive "D"	et and number)		46	. City, Town, or Lo Glen Burnie	ocation of Death		4c. County of Anne Aru		1. 18 5
Funeral Director		5. Social Security Number 6. Sex 212-51-1323		n yrs. last bir 8	rthday) Yrs.	if Under 1 Year Months Days	If Under 24Hrs. Hours Min.	7 .	th(MM/DD/YYYY) 11960	g. Birth; Foreign Coun	Mexico
A		Usual Residence of Decedent  10a. State 10b. County	110	c. City, Town	or Locatio	1					0d. Inside City Limits
1 E.		MD Anne Aru		Glen							1 X Yes 2 No
arylan at onc	Director	10e. Street and Number				10f. Zip Code		1	0g. Citizen of Wha		y?
the M 3a or 2		218 Woodhill Dr	ive Ap	t.D		2106			Mexic	20	
death with the Maryland or items 23a or 28a-f show any must be retified at once,	uneral	11. Marital Status  1 Never Married 2 Married 12.	Was Decedent Ev Armed Forces?			Decedent of Hisp s, specify Cuban,			- 14. Race - White,		n Indian, Black,
	4	3 Widowed 4 Divorced If Ye	Yes 2 X	No	1 X	res 2 No	specify: Mex	ican	Specify:	W	nite
ours, aff	d b	15. Decedent's Education (Specify only high	ates:	eted) 16a.	. Decedent'	s Usual Occupation	on (Give kind of w	ork done	16b. Kind of Bus	iness/Ind	dustry
6 n 72 ho an "n ical Es	ete	Elementary/Secondary (0-12)	College (1-4 or 5+)			emaker	DO NOT use rem	eu)	Own	Ног	ne
21215-0036 uld be filed within 7 Mental Hygiene. marked other than ic event, the Medica	Completed	17. Father's Name (First, Middle, Last)				11	8.Mother's Name	(First, Middle,	Maiden Surname)		
215 be file mtal Hy rked o	å	Apolinar Noyola							en Monro	_	
ore, MD 21215-0036 es I and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once	٢	19a. Informant's Name/Relationship (Type,		1							Zip Cod <b>2</b> 1 0 6 1
Z du Z		David Rico Pating 20a. Method of Disposition		20b. Place	of Disposit	ion (Name of cem		Date	D Glen	City or T	own, State
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filted within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner		1 X Burial 2 Cremation 3 X F	emoval from State	Pant	eon Tita	ීලී <sup>ලා</sup> la Apaseo	12/	31/200	Guana Me:	ajua Xico	ato,
Baltin Permit P Departme Importar		4 Donation 5 Other Specify: 21. Sign tu of Funeral Servic Censee		cucv					RAL SER	VIC	E,P.A.
		23a. Part I. Enter the disease, or complicati	and that council the	a death Dor	924	1 Colum	nbia Bl	vd.Si	lver Sp	ring	Approximate Interval
Physician /Medical		failure. List only one cause on each li	tiple Blunt and					r roopa.c.ry a	, oot, onesk, or mee		Between Onset and Death
xaminer			o (or as a consequ		orce mjo	100					
	ē	Sequentially list conditions, if any, leading to immediate b. Due	o (or as a consequ	uence of):							
	Examine	cause. Enter Underlying Cause (Disease or injury that initiated	o (or as a consequ	ionac of):							
D nd nted	Exa	events resulting in death) Last Due d.									
to, Ge executed sysician and burial - transit	edical	UNPENDED	MENDED #3	as not <b>per M</b>	ed pe D <b>G88</b>	r ME g88 7 1/23/0	37 1/20/ 1 <b>9 TT</b>	09 TT			
68760 certificate b nding physise as the bu	n/Me	23b. Was decedent pregnant in the	Bc. If yes, outcome	-	у	al death 3	Ectopic pregna		23d. Date of of Month	delivery Da	ay Year
Box 68760.  He death certificate y the attending physhed for use as the b	Physician/M	past 12 months?	Pregnant at tin	ne of death	_	er (Specify)					10
the death of the attenty the attenty the attenty the attenthed for us	Phys	1 Yes 2 No 9 V Unknown g	Unknown	ut not resulti	ing in the ur	nderlying cause gi	iven in Part I.	23e. Did	tobacco use contri	bute to t	ne cause of death?
Division of Vital Records, P.O. Box 6876( Hospital or Attending Physician: The law requires that the death certificate 24 hours after death. Funeral Director: After this certificate has been signed by the attending physely filled in by the funeral director, page 2 should be detached for use as the b	þ	3						1 Ye	es 2 🗸 No 3	Proba	ably 4 Unknown
of Vital Records, g Physician: The law require. ther this certificate has been sineral director, page 2 should be	Completed							24a. Was			opsy findings available ompletion of cause of
tal Records cian: The law requi certificate has been ector, page 2 should	omp							perfe 1 <b>✓</b> Yes		eath?	2 No
Vital Rysician: 3	BeC	25. Was case referred to medical examiner?	tal.				of Death (Check				
of Vit Physic er this	2	1 ✓ Yes 2 No 27. Manner of Death	Inpatient label 1 labe		Outpatient o. Time of Ir	Don	Other Nursir	ng Home 5	Residence 6 we how injury occurre		Scene
on of anding Plath.	tion	1 Natural 5 Pending	FOUND: Day, Yea	r) FC	OUND: 25 hrs		es 2 V No		aten, stabbed		ut
Division of V pital or Attending Ph ours after death. reral Director: After I	Certification:	2 Accident Investigation 3 Suicide 6 Could not be	Dec 18, 2008 28e. Place of Injur			t, factory, office bu	uilding, etc.				al Route Number, City
Divisior Hospital or Attend A hours after death Funeral Director: tely filled in by the	Cert	4 Homicide determined	(Specify) Multi						State) I Drive "D", Gler		
To the Hos within 24 h To the Fu	Medical	29a. Certifier 1	the basis of exami	(nowledge, d nation and/o	leath occuri r investigati	ed at the time, da on, in my opinion,	te and place, and death occurred	d due to the cau at the time, date	ise(s) and manner e and place, and d	as state ue to the	d. : cause(s)
To the within 2 To the complete	Med	29b. Signature and title of certifier	manner stated.			29c. License			29d. Date signe		
		- 1///	1			O.C.N	M.E.		December	19, 20	08
OCME		30. Name and address of person who comes Mary G. Ripple MD. Deputy	leted cause of dea Chief Medica			Penn Street,	Baltimore. N	/ID 21201			
St	ate	31 Date filed (Month, Day Year)	32 Registrar's	Signature	Ana	Als p					
Regist	trar	DEC 2 4 2008	DESCUR	1 15	The state of the s						

		1	For State of Maryla		artment of Health and rtificate of Death	Mental Hygie Reg.	2000	43064
	Physicia		Decedent's Name (First, Middle, Last)     Esther Monke			2. Date of Death December	<sup>□</sup> ŽO, 2ŎŐ8	3. Time of Death 11:20P. M
H	/Medic Examin	er '	a. Facility Name (If not institution, give street and number)	0	4b. City, Town, or Location of Deal		4c. County of Death	
	Funeral		Kensington Nursing and Rehabilitation  5. Social Security Number 6. Sex 7. Age (In yrs	s. last birthday)	Kensington  If Under 1 Year If Under 24 Hrs	8. Date of Birth	Montgome 9. Birth	*
H	Director		217-20-9872 1□M 2∏F 8	8 Yrs.	Months Days Hours Min	Jan. 5, 19	20 Mar	place (State or Foreign intry) y Land
	yland			City, Town or Lo				10d. Inside City Limits
	he Mar 28e-f si	5	Maryland Montgomery R  10e. Street and Number	ockvill	.e 10f. Zip Code	100	Citizen of What Cou	1 □Yes 2 XNo
	N with t	ai Dir	3811 Park Lake Drive		20853		United St	•
336	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene.  The most proportion of the more and the statement of the most permit is a marked other than "netural", or items 23e or 28e-f show any injury or other treumatic event. The Medical Evaluation use to colline at ponce.	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced  12. Was Decedent Ever in Armed Forces?  1 □ Yes 2 ☒ No If Yes, Give Year or Dates:		Was Decedent of Hispanic Origin? (: If Yes, specify Cuban, Mexican, Puei 1 ☐ Yes 2ሺ No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Amer Black, White Specify:	
Baltimore, Maryland 21215-0036	within 72 hor ene. then "netur he Medical I	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  12  College (1-4or 5+) 1-4	(Give	dent's Usual Occupation kind of work done during most of wo DO NOT use retired)	orking	Education	ndustry
nd 2	be filed stat Hygi od other event.	Be Co	17. Father's Name (First, Middle, Last)	10000	18. Mother's Na	me (First, Middle, Mai		
ry Ia	should bind Menti a marked umatic e	To	Otto Wielitz  19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	Thekla		ity or Town. State. Z	ip Code)
Ma,	and 2 si ealth an n 27 is r		Melanie van der Lee -daughter		Park Lake Drive	Rockville,	Maryland	20853
imore	Pages 1 ament of He tent: If item		1 ØBurial 2 ☐ Cremation 3 ☐ Removal from State  `4 ☐ Donation 5 ☐ Other (Specify)	cemetery, crer corge Wa	osition (Name of matory or other place) oshington Cemeter	y <b>12/28/</b> 20		i, Mərylənd
Ball	permit, Departn Importe any inju		21. Signature of Funeral Service Licensee  Henseld U. Brywad	44	Name and Address of Facility Onald V. Borgwar 100 Powder Mill R	<u>oad Beltsv</u>	ille, Mar	yland 20 <b>7</b> 05
	Physician /Medical		23a. Part1. Enter the disease, or complication, that caused the deshock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)  a. Alzhe  Due to (or as a conse	imer'	1	ac or respiratory arrest,	,	Approximate Interval Between Onset and Death UNKNOWN
	Examiner	ler	So uentially list conditions b. Due to (or as a conseint any, leading to immediate	equence of):				
8760, G	icate be executed physician and s the burial-transit	ai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  C.  Due to (or as a conse	equence of):				,
		ledica	d					
P.O. Box	The law requires that the death certific ite has been signed by the attending p rage 2 should be detached for use as '	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	Ectopic pregnancy Other (specify)		23d. Date of deli Month	very Day Year	
rds, P.	quires that I n signed by uld be deta		Part II. Other significant conditions contributing to death but not re UPINANY Tract Infect	ion:			cco use contribute to	١.,
		Completed by	Poon intake; Fa dementia	ilure	to Thrive;	24a. Was an autopsy performed	d? prior to death?	topsy findings available completion of cause of
Vita	ysicien: Th is certificate director, pag	Be	25. Was case referred to medical examiner?  1 Yes 2 No Hospital: 1 Inpatient 2	☐ ER/Outpatie	10. 10.	eath (Check only one) Home 5 Residence	e COther (Con	
on of	Attending Physicien: r death. ector: After this certifici by the funeral director,	ition: To	1 Yes 2 No 1 Inpatient 2  27. Magner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident Investigation	28b. Time o		28d. Describe how		aty)
Divis	of or Attending I after death. I Director: After d in by the funer	ertification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At building, etc. (Spe	t home, farm, st ecify)	reet, factory, office	28f. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical C	29a. Certifier (Check only one)  Certifying Physician: To the best of my keep to my keep	ination and/or in	nvestigation, in my opinion, death occ	curred at the time, date	and place, and due	to the cause(s)
		-	20h Circotuse and title of portifier		29c. License number	29d.	. Date signed (Monti	Day Year)
	To th withir To th comp	Σ	29b. Signature and title of certifier		1243121		12/21/2	800
•	To th comp	2	29b. Signature and title of certifier  Chow Chy  30. Name and address of person who completed cause of death (II  NURUL CHOWDHURY, MD; II  31. Date filed (Month, Day, Year)  22. Registrar's Sig	tem 23a) (Type	D43121 DINO DRIVE : B	URTONSUL	12/21/2	720866

DHMH 17 Rev 1/2001

	1	For State Registrar				d / Depa	<b>delible Ink</b> artment of F rtificate of	-lealth	and Me	ntal Hy	_	) ible.	43065
Physicia /Medica	n II —	. Decedent's Name (First, Herbert	Edwar		iller					Date of De Month ルシ	Day 20	Year	3. Time of Death
Examine Funeral Director	5.	. Social Security Number 215–18–9440	Region 18 N	al Me	1 1/	enter ast birthday) Yrs.	4b. City, Town, o	Isbu	iry	. Date of Bir (Month, Da 1/10/	Wi	9. Birthp Cour Mar	olace (State or Foreig phtry) yland
ith the Maryland or 28a-f show	1	0e. Street and Number	icomico			, Town or Lo	10f. Zip Code				10g. Citizen o	f What Cour	0d. Inside City Limits 1 ☑Yes 2 ☐ No
urs a	Completed by Funeral Director	200 Civic  1. Marital Status  1 Never Married 2  3 Widowed 4 in Divice (Specify only)  Elementary/Secondary (0	Married orced cedent's Educat	Armed Force 1  Yes 2 If Yes, Give Year or Date	□ No A <b>rmy</b>	16a. Dece (Give life.	Was Decedent of It If Yes, specify Cub It I I Yes 2 ₺ No dent's Usual Occup kind of work done DO NOT use retire	Hispanic C ean, Mexic Specif	fy:		14. Ra Bl Spec	ace - Americack, White, of the second	etc. hite
ylailu Z.I.  buld be filed wit Mental Hygien arked other the atic event, the	1 0 Re	5 7. Father's Name (First, M unknown	iddle, Last)			roof		unl	known		roof	ime)	
t and 2 sho Health and em 27 is m	1	19a. Informant's Name/Rel Margaret Mi	ationship (Type.	-wife	20b. Pi		ag Address (Street Stock C		Lane,		er, City or Town bury, N		
permit. Pages Department of Important: If its any injury or o	-2	1 □ Burial 2 ☑ Crema 4 □ Donation 5 □ Ott	ner (Specify)	noval from Sta	Sal	isbury	sition (Name of natory or other pla Cremato Name and Addre HOTIOWAY	ry	12/28/	/08	Salish	oury,	
g sign by S	al Examiner	23a. Part1. Enter the disea shock, or heart failure immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, f any, leading to immediate cause. Enter Underlying Cause (Disease or injury hat initiated events esulting in death) Last	a. List only one	Due to (or	as a conseque as a conseque as a conseque	Lence of):	er the mode of dyl	ng, such a	as cardiac or r	espiratory a			Approximate Interval Between Onset and Death
the death certify the attending ched for use as		F FEMALE: 23b. Was decedent pregna in the past 12 months' 1  Yes 2 No 9 Unknown	nt	1 ☐ Live birt	me of pregnan h 2 □ Fetal nt at time of do n	death 3	Ectopic pregnand Other (specify)					ate of delive	ery Day Year
: The law requires that: cate has been signed b. page 2 should be deta	Completed by Pri	Part II. Other significant co	onditions contri	outing to deat	h but not resu	Ilting in the u	nderlying cause giv	ven in Par	t I.	1 ☐ ` 24a. Was autop	Yes 2 No an 24b osy rmed?	3 ☐ Prob	ne cause of death?  pably 4 Unknown  psy findings available  mpletion of cause of  2 UNO
hysici this cer al direct	0 0	2 Accident iii 3 Suicide 6 0	Pending nvestigation	28a. Date of (Month,	Day, Year)	28b. Time o Injury	28c. Inju Wor	ner: 4 🗆 I		5 Resid. Describe	dence 6 O	ırred	(y) al Route Number,
To the Hospital within 24 hours To the Funeral completely filled	edical	29a. Certifier (Check only one) 1 □ Ce (2 □ Me one) 29b. Signature and title of ce	dical Examine	ian: To the best and manner	is of examinat	wledge, deat tion and/or in	h occurred at the tivestigation, in my	opinion, d	leath occurred	d due to the at the time,	cause(s) and place date and place 29d. Date sign	e, and due to	the cause(s)
State Registra	3	10. Name and address of p 11. Date filed (Month, Day, DEC	ARAYAI	11A 32. 18g	of death (Item	SEM	STERN	5/7	IORE	DR	SALIS	BUKY	MD Z1800

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

43065

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death December 24, 2008 **Physician** 1130 William McCray James /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Salisbury Wicomico 27455 S. Bury Drive If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 X M 2 | F 62 220-42-6760 Maryland Director 07/17/1946 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show T is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Worldon Exp., in at 1, must be usuiffed at 1 X Yes 2 □ No Director Wicomico Salisbury Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21801 27455 S. Bury Drive Funeral death \ permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item—any injury or other traumatic event \*\*—. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married If Yes, Give Army Year or Dates: 1 ☐ Yes 2 X No Specify. white Specify: þ 3 Widowed 4 N Divorced Completed 16a. Decedent's Usual Occupation. 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Perdue Farms, Inc. sales 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Carlyn May Metcalf William Edgar McCray ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 202 Ridge Ave., Towson, MD 21286 19a. Informant's Name/Relationship (Type. Print) Robyn McCray/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 12/29/08 Salisbury, MD Salisbury Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Vice see HOTIOWAY Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Met Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending American property filled in by the funeral director. Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Day 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 1 ☐ Yes 2 No 1 ☐Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 K Residence 6 Other (Specify) 1Æ(Yes 2∐No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 🗌 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medican Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Sign ature and title of 29/08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21801 100 E Carroll Jurcler 31. Date filed (Month, Day, Wis 32. Registrar's Signature State 9 2008 Registrar

			1 - For Amend Item 8 Registrar	State of Marylan per fh,g894,	d / Departme 08/11/09dh Certifica	nt of Health and le of Death	Mental Hygie	No. 008	43067
	Physici /Medic		1. Desedent's Name (First, Middle, Last)	Made	dox		12 9	Day Year	3. Time of Death
	Examin	er	45 Facility Name (If not institution, give s	treet and number)	10 Jongin	, Town, or Location of Deal	th	4c. County of Dea	th
ľ	Funeral Director		5. Social Security Number 6. Sex 1 Usual Residence of Decedent	M 20 F 05	last birthday) If Und Months	or 1 Year If Under 24 Hrs Days Hours Min		ar) 9. Bir	thplace (State or Foreign
	death with the Maryland ms 23a or 28a-f ehow roust be notified at	tor	10a. State 10b. County	Mico 100 Cir	y, Town or Location	Y			10d. Inside City Limits
	th with the 23s or 28s	al Director	10e. Street and Number	190 Driv	10f. Z	21801	10g.	Citizen of What Co	ountry?
5-0036	n 72 hours after death with the Marylan "natural", or items 23a or 28a fehow walltal Examiner must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	2. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	If Yes, sp	edent of Hispanic Origin? (Secify Cuban, Mexican, Puer 2 2 No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, Whi Specify:	
0-6171	d within 72 ho piene. Ir than "natur. The Madical I	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		16a. Decedent's Us (Give kind of w life. DO NOT	ork done during most of wo	rking 16b	. Kind of Business	Andustry A
yland 2	be filed tat Hygi d other event,	To Be Co	17. Father's Name (First, Middle, Last)	ck .	i / Ca	18. Mothers Na	me (First, Middle, Maid	den Sumame)	
Mar	and 2 shousalth and Massith and Min 27 is mar		19a Informant's Name/Relationship (Typ	ie, Frint) Nephew	19b. Mailing Address	s (Street and Number or R	bury M	ty Yown, State, .	Zip Code)
aitimore,	Pages 1 nent of He ant: If iter ury or oth		20a. Method of Prisposition  1 Burial 2 Cremation 3 Re  4 Donation 5 Other (Specify)		Place of Disposition (Notemetery, crematory or	mis of		Location - City or	Town, State
ga	permit. Departr Imports any inj	-	21 Signatur of Funeral Service License	all in	Reno R	and Address of Facility	on W. Isa	bella 5	21801
	Physician		23a. Pert1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition	ations that caused the death	h. Do not enter the mo	de of dying, such as cardia	c or respiratory arrest,	<del>)                                    </del>	Approximate Interval Between Onset and Death 5 — with
	/Medical Examiner		resulting in death)	0	uence of):				
4	uted	Examiner	Sequentially list conditions, if any, leeding to immediate cause. Enter Undertying Cause Disease or injury	Due to (or as a consequ	uence of):				
9/00,	cate be executed bhysician and the burial-transit	icai Exa	that initiated events resulting in death) Last	Due to (or as a consequ	uence of):				
. Box 6	ath certific attending p for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	ic. If yes, outcome of pregna 1 Live birth 2 Fetel 4 Pregnant at time of do	I death 3 Ectopic			23d. Date of de Month	livery Day Year
ecords, P.	w requires that the de been signed by the should be detached	þ	Part II. Other significant conditions conf	ributing to death but not resi	ulting in the underlying	cause given in Part !.	23e. Did tobaco		o the cause of death?
L Lec	The lay ate has page 2	Completed					24a. Was an autopsy performed 1 Yes 2	? prior to death?	utopsy findings available completion of cause of 2 \( \subseteq \text{No} \)
ı vıtal	\$ 2 D	To Be	25. Was case referred to medical examiner?  1  Yes 2 No	ospital: 1   Inpatient 2	ER/Outpatient 3□ □	Othor	ath <i>(Check only one)</i> Home 5 🗀 Residence	6 Other (Spe	cify)
DIVISION OF	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	ertification:	27. Manner of Death  1. ☑ Natural 5 ☐ Pending 2. ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in		
Ž	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	O	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	v) 		28f. Location (Street City or Town, St	ate)	
	e Hosp 24 house te Fune detely fi	edicai	29a. Certifier 1 Certifying Physic (Check only one)	cian: To the best of my kno er: On the basis of examina and manner stated.	wledge, death occurre tion and/or investigation	d at the time, date and place n, in my opinion, death occi	e, and due to the cause urred at the time, date	e(s) and manner as and place, and due	s stated. e to the cause(s)
	To the To the comp	Me	29b. Signature and title of certifier	C		C. License number		Date signed (Mont	
9	MAC	1	30. Name and address of person who cor	npleted cause of ateath (Item	BARACINI 123a) (Type, Print)			2-23-0	.0
	Sta	te	31. Date filed (Month, Day, Year) 200	S+ CO	mother thank	M) 218	51	<del></del>	
	Registr		DEC 2 9 200	10 Miller	M. Wallet				

DHMH 17 Rev 1/2001

1. Decedent's Name (First, Middle, Last)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg. No. 2

2. Date of Death

DHMH 17 Rev 1/2001

**ORIGINAL** 

		1- State of Marylan		artment of Hea <i>rtificate of Dea</i>			giene Reg. No. 20	08	43069
Physi /Med		1. Decedent's Name (First, Middle, Last)  Doris Virgini	a M	ills		2. Date of Dea Month Decemb		Year 2008	3. Time of Death 12:11 AM
Exam		4a. Facility Name (If not institution, give street and number)  Frederick Memorial Hospital		4b. City, Town, or Loca Frederic			4c. County	of Death ericl	k
Funera Directo		5. Social Security Number 217-28-5168	last birthday) Yrs.		Inder 24 Hrs. Durs Min.	8. Date of Birth (Month, Day April 16	, Year)	9. Birthp Coun Mary	place (State or Foreign ntry) Land
e Maryland 8a-f show	ector	Maryland Frederick	ty, Town or Lo	Frederick					0d. Inside City Limits 1 □Yes 2 🖾 No
th with th	Funeral Director	1421 Taney Avenue, Apartment 506		10f. Zip Code	02		10g. Citizen of V <b>United</b>		•
1036 nurs after dea al", or items	by Fune	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 ☑ Divorced  12. Was Decedent Ever in U. Armed Forces?  1 □ Yes 2 ☒ No If Yes, Give Year or Dates:		Was Decedent of Hispan If Yes, specify Cuban, Me 1 □Yes 2 X No <i>Sp</i>	nic Origin? (Spe exican, Puerto ecify:	ecify Yes or No- Rican, etc.)	14. Rac Blac Specify	e - Americ k, White, e : Wh:	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exprinipar nast to redified at	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Give life.	dent's Usual Occupation kind of work done during DO NOT use retired)  se Keeper	g most of workin	ng	Seconda Educati	ry	dustry
yland y buld be filed Mental Hyg arked other	To Be C	17. Father's Name (First, Middle, Last) Irving M. Biser		18.	Virginia	L. Stewa			
and 2 sho salth and n 27 is m		19a. Informant's Name/Relationship (Type. Print)  David Mills / Son	1	ng Address (Street and N Autumn Leaf L					Code)
altimore, rmit. Pages 1 ar partment of Hea portant: If item :		20a. Method of Disposition  1 \( \begin{array}{cccccccccccccccccccccccccccccccccccc	st Refo	osition (Name of matory or other place) rmed United hrist Cemetery	Decemb 31, 20	oer 008	20c. Location - Middleto	-	
Balt permit. Depart Import any inj	S S	21. Signature of Funeral Service Licensee	Ŕ	2. Name and Address of eeney & Basfor O6 East Church	Facility d P.A. Fu	neral Hor Frederic	me k, Maryla	nd 217	701
Physiciar /Medica Examine		resulting in death)  Due to or as a conseq	ARD 1	ter the mode of dying, su	oh as cardiac o	r respiratory arr	nest,		Approximate Interval Between Onset and Death
Hospital or Attending Physician: The law requires that the death certificate be executed thours after death.  Funeral Director: After this certificate has been signed by the attending physician and ittely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of the consequen							
P.O. BOX 6  nat the death certification of the attending of the attending of the teached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 Mo 9 □ Unknown  23c. If yes, outcome of pregnat 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of 6 9 □ Unknown	al death 3	Ectopic pregnancy Other (specify)			23d. Dat Mo	e of delive nth	ery Day Year
cords, P.O. w requires that the do been signed by the should be detached	þ	Part II. Other significant conditions contributing to death but not res	ulting in the u	nderlying cause given in	Part I.		bacco use contr	ribute to th	ne cause of death?
DIVISION OT VITAI RECORDS, if or Attending Physician: The law requires thater death.  Director: After this certificate has been signed in by the funeral director, page 2 should be done.	Completed					24a. Was a autops perfori	sy p med2 c	Were autop prior to con death? I □ Yes	psy findings available mpletion of cause of 2 No
r VIII  nysician  nis certiff  director	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital: 1 Inpatient 2 ☐	ER/Outpatie	Other		(Check only on me 5 ☐ Reside	ne) ence 6 ∏Oth	er (Specify	γ)
Attending Ph death. ctor: After th y the funeral	Certification: To	27. Manner of Death  1 ★ Natural 5 Pending investigation  2 Accident 6 Could not be	28b. Time o Injury	M 1 ☐ Yes	2 □No	-62	ow injury occurr		
DIVISIC  To the Hospital or Attent within 24 hours after deat! To the Funeral Director: completely filled in by the		3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rural Route Number of Street and Number or Rural Route Number of Street and Numbe							
he Hosp in 24 hou he Fune pletely fi	edical	29a. Certifier (Check only one)  Certifying Physician: To the best of my known and manner stated.	owledge, deat ation and/or in	h occurred at the time, do	ate and place, and death occurre	and due to the ded at the time, d	cause(s) and ma date and place, a	inner as st and due to	tated. the cause(s)
To the within 2 To the comple	×	29b. Signature and title of certifier  New Flow, MD		29c. License num	Et a	2	29d. Date signed		12008
2		30. Name and address of person who completed cause of death (Iter Florin Rusu, M.D. 400 West Seventh	Street,		ryland 2	L701			
S Regis	tate trar	31. Date filed (Month, Day, Year)  32. Registrar's Signa  JAN 1 2 2009 Servera A.							
DHMH 17 Rev 1	/2001	one 2 6 2003 person B. of	OF	IGINAL					

			1 _ State	te of Maryland / Depa	ertment of H Stificate of L			iene :g. No. 200	8 43070
			Registrar  1. Decedent's Name (First, Middle, Last)				2. Date of Deat		3. Time of Death
	Physicia /Medic		JUDITH M.	NEARING			1 <sup>Month</sup>	2 <sup>Day</sup> You	7:15 AM
	Examin	er	4a. Facility Name (If not institution, give street a 14712 HAROLD ROAD	nd number)	-	Location of Death SPRING		4c. County of De MONTGOME	
	Funeral		5. Social Security Number 6. Sex 1 □ M 2 5	7. Age (In yrs. last birthday) 7. Trs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 10-27-1	Year) 9. B	irthplace (State or Foreign Country)
H	Director		728-07-1185	7.5 118.			10-27-1	933   0]	HIO
	rylano show	_	10a. State 10b. County	10c. City, Town or Loc					10d. Inside City Limits
	the Ma 28a-f	Director	DELAWARE SUSSEX  10e. Street and Number	OCEAN V	LEW 10f. Zip Code		110	og. Citizen of What C	1 XYes 2 No
	h with 23a or		20 SOUTH PRIMROSE LAN	NE	19970			US	
30	within 72 hours after death with the Maryland jiene. r than "natural", or items 23a or 28a-f show the fire Medical Examiner must be profilled at	by Funeral	1 Never Married 2 Married	ned Forces? If  Yes 2 [X] No es, Give 1	Was Decedent of Hi fYes, specify Cuba I□Yes 2∏ No	ispanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - An Black, Wh Specify:	
9500-91212	2 hours latural* ical Ex		15. Decedent's Education	r or Dates:	dent's Usual Occupa	ation	·	16b. Kind of Busines	
121	vithin 7 nne. han "n	Completed		ege (1-4or 5+)	kind of work done a OO NOT use retired,	luring most of work )		CAMDODOUNI	
	Hyg Hyg ther nt,	Be Co	12 17. Father's Name (First, Middle, Last)	KEG.	ISTRAR	18. Mother's Name		CAMPGROUNI faiden Surname)	
Maryland	0 0 0 0	To B	GEORGE A. HARTMEYER			VIRGIN	IA BOYD		
Mar			19a. Informant's Name/Relationship (Type. Prin					City or Town, State,	
ďΣ	and deal		CHARLOTTE R. WHALEN/E 20a. Method of Disposition	20b. Place of Dispos				RD, DE. 1	
Baltimore,	Page ment o ant: If ury or		1 X Burial 2 ☐ Cremation 3 ☐ Removal 4 ☐ Donation 5 ☐ Other (Specify)	ST. GEORG	GE'S CEME	TERÝ 12-2			DELAWARE
Rail	permit. Pages 1 Department of H Important: If Ite any injury or ot once.		21. Signature of Funeral Service Licensee		Name and Addrese BLSON FUN EST AVENU	ERAL SERVE, OCEAN	VICES, LT	D ELAWARE. 1	19970
			23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one caus	that caused the death. Do not ente	er the mode of dying	g, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	ue to (or as a consequence of):					
	Examiner		Sequentially list conditions. b	V					
	uted I nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events c.	ue to (or as a consequence of):					
Ď,	ficate be executed physician and s the burial-transit	Exa	resulting in death) Lest	ue to (or as e consequence of):					
9/80	physic the bu	dical	d			<del></del>			
C. Box c	ath certi attending for use a	Physician/Me	in the past 12 months?		Ectopic pregnancy Other (specify)	/		23d. Date of d Month	elivery Day Year
ds, P.	w requires that the de been signed by the should be detached	by	Part II. Other significent conditions contributing	g to death but not resulting in the ur	nderlying cause give	en in Part I.	23e. Did tob		to the cause of death?
Hecords,	e la has	Completed					24a. Was ar autops perforn	y prior to	autopsy findings available completion of cause of
Vital	ilcian: Th certificate rector, pag	Be Co	25. Was cese referred to medical			26. Place of Deat	1 □Yes 2	No 1 □Ye	es 2 DNO
01 <	Physician: this certific	To B	examiner? 1 ☐ Yes 2 No Hospital	1 Inpatient 2 LER/Outpatien		4 LI Nursing Ho	ome 5 Reside	. /	
ono	iding Physician: th. After this certifical funeral director, p	tion:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	Date of Injury (Month, Day, Year) 28b. Time of Injury	Work	yat (? Yes 2∐No	28d. Describe ho	w injury occurred	
DIVISION	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	2 Could not be	Place of Injury - At home, farm, stre building, etc. (Specify)	eet, factory, office		28f. Location (St. City or Town	reet and Number or I , State)	Rural Route Number,
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	Medical C	(Check only 2 Medical Examiner: Or	To the best of my knowledge, death the basis of examination and/or indicated.					
	To the vithing compared to the	Me	29b. Signature and title of certifier	Uz NO	29c. License	. Aum	7	9d. Date signed (Mor	nth, Day, Year)
p	ALIA		30. Name and address of person who complete	d cause of death (Item 23a) (Type, I	Print)		a A71 A	16 AV	MILLVILLER
V-	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Signature	ra ner	_ 60	1711410	IIU AVE	
	Registr	ar	DEC 2 4 2008	Blown H.	Sperte				19967

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2008 2. Date of Death 1. Decedent's Name (First, Middle, Last) Worth Day 30, Year December 30, 2008 11:10A M **Physician** Harold Gale Poling /Medical 4c. Counfy of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Harford Abingdon 4031 Sharilynn Drive If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 11/25/1937 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. West Virginia 71 216-36-7914 Director Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits ть 23a or 28a-f show must be notified at Director Harford Abingdon 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 should be filed within 72 hours after death with and Mental Hygiene.

is marked other than "natural", or items 23a or 21009 U.S.A. 4031 Sharilynn Dr. 7 is marked other than "natural", or items 23a traumatic event, the Medical Examiner must be Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ Specify. Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Delivery Driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ervin James Poling, Sr. Olga Mae Norman ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any Injury or other trau
once. 21009 Hilda Poling (Spouse) 4031 Sharilynn Dr. Abingdon, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State tX Burial 2 ☐ Cremation 3 ☐ Removal from State 1/3/09 Harford Mem. Gdns. Aberdeen, Maryland 4 ☐ Donation 5 ☐ Other (Specify) <sup>22</sup> Name and Address of Facility Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399 21. Signature 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** metastano disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the burial-transi Due to (or as a consequence of) P.O. Box 68760, physician Physician/Medical signed by the attending plant of the detached for use as t IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by No 3 Probably 4 Unknown 1 🗌 Yes page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 1 ☐ Yes 2 No funeral director, 25. Was case referred to medical examiner?. Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Hospital or Attending 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident hours after death 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

State Registrar

31. Date filed (Month, Day, Year) JAN 1 2 2009

29b. Signature and title of certifier

·SIUASATURIN suite 200 32. Registrar's Signature

iowaila 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D45530

29d. Date signed (Month, Day, Year)

602 S At wood, Belain MD21014

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Augustus L. Palmer, Jr. Dec 19 2008 11:22PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Montgomery Silver Spring If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Months 112 M 2 F 57 Director 461-96-1376 Virginia 28, 1951 Usual Residence of Decedent 10c. City, Town or Location 10a State 10h. County 10d. Inside City Limits 28a-f show event, the Medical Examiner must be notified at Director 1√EYes 2 No MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 9516 Hale Place 20910 United States or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. African 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify: Specify: American þ 3 Widowed 4 Divorced 'natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Management nd Mental Hygiene. marked other than College (1-4or 5+) Elementary/Secondary (0-12) Consulting Firm Chief Financial Officer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) id 2 should be fill th and Mental H 27 Is marked other traumatic even Be Augustus L. Palmer Mercedes Hardwick ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an Denise Robinson-Palmer 9516 Hale Place, Silver Spring, Maryland 20910 Department of Health Important: If item 27 any injury or other troope. 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Chesapeake Crematory 12/30/08 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McGuire Funeral Service, Inc. PIma 7400 Georgia Avenue, N.W. Wash., D.C. 20012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Cardiorespiratory Arrest disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sepsis Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) law requires that the death certificate be executed and burial-tran that initiated events Pneumonia resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physician Physician/Medical Altered Mental Status the attending philosophers are the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 Other (specify) 1 □Yes 2 □No the detached 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been sign page 2 should be Intracranial bleed Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? Morbid obesity has autopsy performed? Physician: The certificate 1 ☐ Yes HTN 2 No 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) 1∐Yes 2√2No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 Pending investigation 1 Natural
2 ☐ Accident death. 1 ☐ Yes 2 ☐ No To the Hospital or Attend within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide \*\*Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1 68096 20108 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Road Silver Spring, MD. 20910-1484 Satyam A. Shah 31. Date filed (Month, Day, Year) Registrar's Signature State DEC 24 Registrar

State of Maryland / Department of Health and Mental Hygien ? 0 0 8 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month 02:05 PM December Robert John Purvis 20, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel 8. Date of Birth (Month, Day, Year) Nov. 10, 1 If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** MM 2□ F Nov. 1947 Great Britain 61 Director 557-69-9594 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, It a Madical Examinations be notified at Director 1 ☐ Yes 2 XXVo Maryland Anne Arundel Gambrills death with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21054 Funeral 2491 Symphony Ln. U.S.A. permit. Pages 1 and 2 should be filed within 72 hours after dear Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itemany Injury or other traumatic event in the ones. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married XX Married 1 □Yes 2XNo Specify: þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Certified Public Accountant 5+ Accounting 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Purvis ౖ Joyce Mary Flower 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louise Skinner (Wife) 2491 Symphony Ln. Gambrills, MD 21054 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2XXCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12-23-2008 Lee Crematory Clinton, MD 21. Ignature of uneral Service Ligenses 22. Name and Address of Facility Lee Funeral Home, Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line.

Immediate cause (Prial disease) conditions as a condition of the conditions of the condition of the conditions of the conditions of the condition of the conditions of the condition of the conditions of the condition of the condi 6633 Old Alexandria Ferry Rd. Clinton, MD 20735 Approximate Interval Between Onset and Death **Physician** TEAS /Medical Due to (or a a consequance of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): The law requires that the death certificate be executed physician and s the burial-trans resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.O. s been signed by the should be detached 1 ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? s certificate has build irector, page 2 st 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 □ Yes To the Hospital or Attending Physiclan: within 24 hours after death.
To the Funeral Director: After this certifics director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No After this of funeral direction 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Mariner of Death 28a Date of Injury 28b Time of 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 2 Accident 5 Pending investigation neral Director: A filled in by the fu 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical npletely (Check only one) 29b. Signature and title of certifier hem , MI) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 Bestaget Road #300, Anneyolis Min Ziyo MP DB 15 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

Registrar

DEC 2 3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year 2008 **Physician** JEAN RENE POIRIER December 7 58  $\Delta^{M}$ /Medical 4a. Facility Name (If not institution, give street and number) 4h City Town or Location of Death 4c. County of Death Examiner Frederick Frederick Frederick Memorial Hospital 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 3 km 2 F 79 034-20-4905 Director June 19, 1929 Massachusetts Usual Residence of Decedent 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits show Maryland Frederick 1 □Yes ≱ No Director Thurmont 28a-f 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ms 23a or 8213 B. Stevens Road 21788 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 7 Is marked other than "natural", or iten traumatic event, the Medical Examinate 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 TxNo Specify. White 2 Specify: 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any Injury or other traumatic event, Item Monce. Elementary/Secondary (0-12) College (1-4or 5+) Physician Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Raoul Rene Poirier Theresa LaPointe ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cheryl Lee Poirier - daughter 2250 Bear Den Road, Frederick, Maryland 21702 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Stauffer Crematory 12-16-2008 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Blast 1210 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit Due to (or as a consequence of): Physician/Medical as the b attending IF FEMALE: for use yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Dav Year 5 Other (specify) the 9 Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 GPA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy perform After this certificate 1 □ Yes 2 1 No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 4NO Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 3 Natural n 24 hours after death.

e Funeral Director: A letely filled in by the fu 2 Accident 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

the within To the

Hospital or Attending Physician:

death.

29a. Certifier

(Check only

29b. Signature and title of certified

31. Date filed (Month Car Year)

Ca Ten

Medical

law requires that the death certificate be execu

P.O. Box 68760.

Division of Vital Records,

with the Maryland

Pages 1 and 2 should be filed within 72 hours after

altimore, Maryland 21215-0036

DHMH 17 Rev 1/2001

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

400 W. 7th Street, Frederick, Maryland

32. Redistrar's Signature

1 Lettifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

MDD66166

29d. Date signed (Month, Day, Year)

0

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar	Maryland / L		tificate of L			Iene ∍g. No.2 ∩ ∩	Ω	1.3075	
	Dhyaisi		1. Decedent's Name (First, Middle, Last)			***		2. Date of Death	h	ear	3. Time of Death	
· A	Physici /Medio		James Edwa		Sr			December	27, 200	88	0602 A <sup>M</sup>	
,	Examir	er	4a. Facility Name (If not institution, give street and numb	er)			Location of Death		4c. County of I			
***	Funeral	-	1972 Old Elk Neck Road  5. Social Security Number 6. Sex 7.	Age (In yrs. last birt	thday)	Elkton If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Ceci		ace (State or Foreign	
	Director		217-74-4195 <sup>1</sup> \\ \(\Omega\) M 2 □ F	52	Yrs.	Months Days	Hours Min.	(Month, Day, Year) SEPT 30, 1956 Maryland				
	land ow		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town	or Loc	ation				10	d. Inside City Limits	
	be filed within 72 hours after death with the Maryland thal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Evention.	ctor	Maryland Cecil	E1kto	on						1 □Yes 2 💢 No	
	or 28	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of Wha	t Count	ry?	
	sath w		1972 Old Elk Neck Road			21921			United			
	ter de	Funeral	11. Marital Status 12. Was Deceded Armed Force 1 □ Never Married 2 1 Married 1 □ Yes 2	es?		Vas Decedent of His Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race Black, V			
21215-0036	al", or	þ	If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Date		1	□Yes 2XINo	Specify:		Specify:	Whi	te	
5	72 ho	Completed	15. Decedent's Education (Specify only highest grade completed)	16a.	Deced	ent's Usual Occupa kind of work done d OO NOT use retired)	ation uring most of worki	na I	16b. Kind of Busin	ess/Ind	ustry	
121	within ene. than '	dmo	Elementary/Secondary (0-12) College (1-4	or 5+)					Tr1			
<u>0</u>	filed Hygi other ent, II	Be Co	17. Father's Name (First, Middle, Last)		III	ıck Drive	18. Mother's Name	(First, Middle, N	Truck:	Lng		
<u>lan</u>		70 B	William F. Price, Sr.				Margare	et Ann Sl	nerman			
Maryland	2 should I and Men is marke aumatic		19a. Informant's Name/Relationship (Type. Print)	19b.	Mailin	g Address (Street a	and Number or Rura	al Route Number,	City or Town, Sta	te, Zip	Code)	
	is 1 and 2 should of Health and Mer item 27 is marke other traumatic	Ш	Kathy Price/Wife			Old Elk N						
Baltimore,	Pages 1 nent of 1: int; If ite iry or ot		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from Sta	ue		sition (Name of atory or other place	ounua.	ry 2,	20c. Location - City			
≣	. = 0 =		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licensee	Hickory		ve Cemetery			Port Pen	n, I	DE	
Ba	permit Depart Import any Inj once.		I have be the	ha	H:	Name and Addresicks Home 03 W. Sto	for Fune	erals, P Teet, Ell	.A. kton. MD	21	921	
			23a. Part 1. Enter the disease, or complications that cau shock, or heart failure. List only one cause on each	sed the death. Do n h line.							Approximate Interval Between	
Line Bar	Physician	Ü	Immediate Cause (Final disease or condition resulting in death)	reatic	Ca	ncer					Onset and Death	
Fee	/Medical Examiner		Due to (or	as a consequence o	of):							
		er	Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or injury	as a consequence o	of):					-		
16	cuted nd ransit	Examiner	that initiated events									
Ď.	icate be executed physician and the burial-transit	I Ex	resulting in death) Last Due to (or	as a consequence o	of):							
68760,	tificate be executed g physician and as the burial-transit	edical	d							-		
			IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outco						23d. Date of	delive		
. Box	requires that the death cei een signed by the attendir nould be detached for use	sician/IV	in the past 12 months?	h 2□ Fetal death nt at time of death		Ectopic pregnancy Other (specify)			Month		Day Year	
д. О	w requires that the de s been signed by the should be detached	Phys	9 ☐ Unknown									
Ś.	res th	ρ	Part II. Other significant conditions contributing to deat	h but not resulting in	the un	derlying cause give	n in Part I.		acco use contribu			
Š		eted								Proba	ibly 4 🗌 Unknown	
Records,	sician: The law certificate has b irector, page 2 sl	ompleted						24a. Was an autopsy perform	prior	to com	sy findings available pletion of cause of	
	an: Tl tificate or, pa	C	25. Was case referred to medical				26. Place of Death	1 □ Yes 2	No 1 🗆	Yes 1	2 🗆 No	
	Physician: rthis certific ral director,	0 B	examiner?	atient 2 ER/Out	patient	Otho			nce 6 Other (	Specify	)	
	ng Ph ffer th ineral	on: T	27. Manner of Death 28a. Date of	njury 28b. Ti <i>Day, Year)</i> In	ime of ijury	28c. Injury Work	at :	28d. Describe how		5,000,		
<u> </u>	Attending r death. sctor: After by the fune	cati	2 Accident investigation				es 2□No					
		Certification:	dotormined 266. Place of	Injury - At home, fari etc. (Specify)	m, stre	et, factory, office	1	28f. Location (Str. City or Town,	eet and Number o State)	r Rural	Route Number,	
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in		29a. Certifier Certifying Physician: To the be	st of my knowledge,	death	occurred at the tim	e, date and place,	and due to the ca	use(s) and manne	er as sta	ated.	
	the Ho nin 24 the Fu thete	Medical	(Check only 2 Medical Examiner: On the basione) and manner	s of examination and stated.	d/or inv	estigation, in my op	inion, death occurr	ed at the time, da	te and place, and	due to	the cause(s)	
_	Vitt	2	29b. Signature and title of certifier			29c. License		29	d. Date signed (M	onth, D	ay, Year)	
			30 Name and address of account	f death (lt 00-) 0	T		4086		ecember	29,	2008	
	3		30. Name and address of person who completed cause of Jamil Khatri, M.D., 111 W				104, E1kt	on, MD	21921			
	Sta		31. Date filed (Month, Day, Year) 32. Reg	strar's Signature			,	,				
	Registr	ar	JAN 1 2 2009 Brown	A. Joa	uto							

4	3	0	7	6

State of Maryland / Department of Health and Mental Hygiene 2 [] [] 8 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dec. 24, 2008 **Physician** Luisa Rivera Rosales 1:25pm /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Holy Cross Hospital Silver Spring Maryland June 20, 1936 Guatemala 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1□ M 2 F Months Days Hours 72 217-17-9769 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show are injury or other traumatic event, the Medical Experiment must be notified at once. MD Rockville Montgomery 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4104 Elizabeth Street 20853 Guatemala Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 14. Race - American Indian. 11. Marital Status 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1⊠Yes 2□No Specify: Guatemalan White If Yes, Give Year or Dates ģ 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gregorio Rivera Petrona Rosales ို 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rudy Moran/Son 4104 Elizabeth Street Rockville, Md. 20853 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cemeterio de Chiquimula 20c. Location - City or Town, State Chiquimula, Guatemala Date 20a. Method of Disposition 1/03/2009 1 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service PHITIPADESSRIMALDI FUNERAL SERVICE, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear railure. List only one cause on each line. 9241 Columbia Blvd.Silver Spring, Md20910 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Liver Cancer disease or condition resulting in death) years /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the burn completely filled in by the funeral director, page 2 should be detached for use as the burn. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) 1 ☐ Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? coagulopathy due to liver failure 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐No. 1 □ Yes 20 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 12-24- 2008 D 0065485 Rem My parech 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Road Silver Spring, Md20910 Barbara Supanich MD

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month Des CY

32. Retistrar's Signature

Box 68760. P.0. Division of Vital Records.

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December 20, 2008 9:38 рм **Physician** J. Nicholas Rossi /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Co. Temple Hills 2113 Colebrooke Drive If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye April 29, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year) Days Min. 1 M 2 F 1945 Washington D.C. 63 578-58-6695 Director Usual Residence of Decedent be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any Injury or other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes XX No Temple Hills Maryland Prince George's Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2113 Colebrooke Drive United States 20748 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ∐Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2XX arried Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify. Specify: White Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Government Contractor Builder 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Louis Rossi Louise Torre 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2113 Colebrooke Drive, Temple Hills, MD 20748 19a. Informant's Name/Relationship (Type. Print) Brenda Rossi (Wife) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Clinton, Maryland Lee Crematory Dec 24, 2008 4 □ Donation 5 □ Other (Specify) 22. Name and Address of FacilityLee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, MD 23a, 9art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** The try takic disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) law requires that the death certificate be executed Exami ng physician and as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 9 Unknown 9 Unknown by signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ò 2 🗌 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t autopsy performed? 1 Yes 2 No certificate I 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After t 1 Natural 2 ☐ Accident 5 Pending To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fun 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Jecember, 22, 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jr#170

Registrar DHMH 17 Rev 1/2001

State

635

31. Date filed (Month, Day, Year)

OROYC

2

3

DEC

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 200 bert 200 comber /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Himore If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 1 M 2 □ F If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Year Days Min Months 217-60-386 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f show 1 ☐Yes 2 No Glen Director Burnie Anne 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2104 21060 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ Ho If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 Specify. þ Specify: white 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) than " Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiene Important: If item 27 is marked other than any Injury or other traumatic event, It alone. lanaa 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 114 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Jown, State, Zip Code) GlenBurnie haron Md 21060 (<u>ioodwood</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12-29-09 Hanover 22. Name and Address of Ficility Daugherty 21. Sign ture of Funeral Service Licensee 2601 Mountain Rd. tasadena Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease or complications that edused the death shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final on. **Physician** disease or condition resulting in death) /Medical Examiner a RON Squartially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) After this certificate has been signed by the functional director, page 2 should be detached 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 2 🗌 No 3 ☐ Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? Yes 2 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes, 2 DNo 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manuer of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 TYes 2 ∏No 2 Accident filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a

To the Funeral C

completely filled 29a. Certifier 1 🛈 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 1/2001

10

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink., Ensure All Copies Are Legible.

AMEND TTEM#30perDVR, G887, 1/12/09, WS
State of Maryland/ Department of Health and Mental Hygiene 1 - State Registrar Reg. No Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** ELIZABETH ROLAND DEC. 29 2008 8:45 PM /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner SOUTHERN MARYLAND HOSPITAL CLINTON GEORGE'S If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** Months Days 1 □ M 2 🕅 F 82 Yrs. 578-28-9727 28.1926 MARYLAND Director MAYUsual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 28a-f show 1 ∏Yes 2 TXNo Department of Health and Mental Hygiene. Important; friem 27 is marked other than "natural", or items 23a or 28a-f stany injury or other traumatic event, the Modical Example and the control once. Director PR. GEORGE'S FORT WASHINGTON MD death with the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 12021 LIVINGSTON ROAD 20744 S. A. Funeral 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces' Black White etc. 72 hours after 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ **3** Widowed 4 □ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) I Hygiene. filed within Elementary/Secondary (0-12) College (1-4or 5+) 11 HOMEMAKER VU HOWE s 1 and 2 should be filed wi f Health and Mental Hygien tem 27 is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be VIVIAN DENT MARY GIBBONS ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) ROSE BARRETT/DAUGHTER 11228 RAWHIDE RD. LUSBY, MD 20657 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 JANUARY 1 ☐ Burial 24 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) METRO . CREMATORY 1, 2009 ALEXANDRIA, VA. permit. 22. Name and Address of Facility RAYMOND FUNL.SERVICE, P.A. 21. Signature of Funeral Service L 5635 WASHINGTON AVE., LA PLATA, MD M00641 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of a call the cause of th Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine be executed and resulting in death) Last Due to (or physician a s the burial-t Physician/Medical as attending properties for use as IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.0. □Yes 2□No the 9 I Unknown 9 Unknown signed by t t be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an nas page 2 s autopsy certificate 1 □Yes 2 D2No 1 TYes 2 No ospital or Attending Physician: hours after death. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To After this 27. May er of Death 1 Natural funeral Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Injury 1 ☐ Yes 2 ☐ No Il Director: / 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral I

completely filled To the Hospital 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7700 OLd Branch Ave Suite c-101 Clinton, MD 20735 Laxmi N. Berwa

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygien ?

	i	ŀ	T = For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment of rtificate o	Health a	nd Mental I	Hygiene Reg. No.		43081					
	Physici		Decedent's Name (First, Middle, La	'	r Cecil Sm	ith		2. Date o Month Decen	Day	Year 3, 2008	3. Time of Death 7:43 A					
	/Medio Examir		4a. Facility Name (If not institution, given 14623 Olsen Lane				n, or Location of			County of Death  Washin	1					
-	Funeral		Social Security Number     6. S		e (In yrs. last birthday,	If Under 1 Ye Months Day		Min. (Month	, Day, Year)	9. Birth	place (State or Foreign intry)					
ŀ	Director		218-50-6835 Usual Residence of Decedent	. X	45 Yrs.			May 2	6, 196	53   Ma	ryland					
	aryland show	_	10a. State 10b. County		10c. City, Town or Lo						10d. Inside City Limits					
	the Ma 28a-f s	Director	Maryland Washin  10e. Street and Number	ngton		Cascad			10a Citis	Top of Milest Co.	1 ☐ Yes 2x No					
	with t	Dir	14623 Olsen Lane	2			e 21719			zen of What Cou	intry?					
	death	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13.			in? (Specify Yes o Puerto Rican, etc.		14. Race - Amer						
36	irs after il", or ite xamine	by Fu	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 If Yes, Give Year or Dates:	No	1 ☐ Yes 2 🔀 N		, Fuello nicali, etc.		Black, White Specify: Wh	ite					
21215-0036	72 hou natura lical E	ted l	15. Decedent's E (Specify only highest gro	ducation	16a. Dece	dent's Usual Oc	cupation	of working	16b. Kir	nd of Business/I						
121	vithin 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5	i+) life.	kind of work do. DO NOT use ret Machin		or working		Daintin	~					
d 2	filed v Hygie other t		12 17. Father's Name (First, Middle, Last	·)		Machilli		's Name (First, Mic		Printin	.9					
/an	Aental rked c	To Be	Roger Hamil:	ola Co	sgrove											
Maryland	2 short and Instruction	The second state of the se														
e, r	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		Angela Marie Sm. 20a. Method of Disposition	ith (Wif	e) 1462 20b. Place of Dispo			scade, Ma		21719 cation - City or T	Town State					
Baltimore,			1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specia	Removal from State	Bethel C	matory or other p	place)	January 1, 2009		caudi - City of 1 scade, M						
altir	permit. Pag Department Important: I any Injury o once.		21. Signature of Funeral Service Lice	nsee	2	2. Name and Ad	dress of Facility			uneral	_					
8	e III e		Tope Lee.	Davis	MO1414 1.	2525 Bra	adbury A	Ave. Smit	hsburg	, Maryl	and 21783					
п			shock, or heart failure. List only	Approximate fine disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):												
	Physicián /Medical		disease or condition resulting in death)	a	Carcino,	1	Non				Syears					
20	Examiner		Commendation link and distance	h	a consequence or,											
V	pe sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  c													
20	be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or as	a consequence of):											
8760,	ate be e hysician he burik			d												
89	nd phy as th	Physician/Medical	IF FEMALE:													
Вох	death certific attending pl	ian/	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	Ectopic pregna			2	23d. Date of delive	very Day Year					
P.0.	at the de by the a tached	nysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time or death 5	Other (specify					•					
S, P	as thi	by Pł	Part II. Other significant conditions	contributing to death b	ut not resulting in the u	nderlying cause	given in Part I.	23e. [			the cause of death?					
or Vital Records,	w require been się should b				-			_ 1	☐ Yes 2☐	⊋√No 3□Pro	bably 4 □Unknown					
Rec	has b	Completed						a	Vas an utopsy erformed?	24b. Were aut prior to co death?	opsy findings available ompletion of cause of					
ta			25. Was case referred to medical				26 Place	1	es 2 No	1 ☐ Yes	2□No					
Ž	S S =	To Be	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	nt 2 ☐ ER/Outpatie	nt 3□ DOA	Othor:	sing Home 5		G □Other (Spec	(fv)					
n o	ding Phy I. After thi funeral o		27. Manner of Death 1 ☑ Natural 5 ☑ Pending	28a. Date of Inju (Month, Da	ry 28b. Time o	V	njury at Vork?		be how injury							
Division	or Attending ther death. Director: After in by the funer	icati	2 Accident investigation 3 Suicide 6 Could not b	e 28a Place of init	ury - At home, farm, st		Yes 2 N		- Church	-1 N 1	- Courte Manager					
Div	al or A s after al Direct	Certification:	4 ☐ Homicide determined	building, et	c. (Specify)	eet, lactory, one	o <del>c</del>	City or	Town, State)	)	al Route Number,					
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Example	miner: On the basis o	of my knowledge, deat f examination and/or in	h occurred at the	e time, date and ny opinion, deat	d place, and due to h occurred at the ti	the cause(s) me, date and	and manner as	stated. to the cause(s)					
	To the within 2 To the сотрые	Med	29b. Signature and title of certifier	and manner sta	ated.	29c. Lice	ense number		29d. Date	e signed (Month	Day, Year)					
	F > F 0		I milano	Mulon	MA	0	4160	5 7								
	1h		30. Name and address of person who					-		,	.09					
	1/2		Michael Month Day Van	Mc Corn	ce(C 11/1	o M	edical	Canal	ivs li	treento	un MO					
	Sta Registr	_	31. Date filed (Month, Day, Year)	14"	ar's Signature	2		•								

			_ FOr	Maryland /	Department of H			000 1000
			State Registrar		Certificate of L		Reg. No.2	
T	Physici		1. Decedent's Name (First, Middle, Last)  THELM H	5	PRINGE	↑ Mc	te of Death onth Day cember 20	3. Time of Death 9:48 a M
No.	/Medio		4a. Facility Name (If not institution, give street and num 401 West Lincoln Avenue	Apt 106	4b. City, Town, or <b>Emmits</b>	Location of Death	4c. Co	unty of Death rederick
L .	Funeral Director		214-36-0069 1□M 2▼F	7. Age (In yrs. last i	birthday) If Under 1 Year Months Days	Hours Min. 8. Da	te of Birth onth, Day, Year) E 17, 1937	9. Birthplace (State or Foreign Country)     Maryland
	Maryland f show ed at	jo.	Usual Residence of Decedent  10a. State 10b. County  Maryland Frederick	10c. City, To	own or Location	Emmitsburg		10d. Inside City Limits 1   Yes 2   No
	a or 28a- st be notifi	Funeral Director	10e. Street and Number 401 West Lincoln Avenue,	Apt 106	10f. Zip Code	21727	_	of What Country?
980	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 ▼ Divorced  12. Was Dece Armed For 1 □ Yes If Yes, Give Year or Da	2 <b>™</b> No	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	ispanic Origin? (Specify Ye in, Mexican, Puerto Rican, Specify:	etc.)	Race - American Indian, Black, White, etc. Decify: white
Maryland 21215-0036	I within 72 ho jiene. r than "natur the Medical I	Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1		6a. Decedent's Usual Occup (Give kind of work done of life. DO NOT use retired COOK	during most of working	Î	of Business/Industry
land 2	d 2 should be filed within th and Mental Hygiene. 7 is marked other than "traumatic event, the Mec	To Be C	17. Father's Name (First, Middle, Last)  John Henry Trent	•		18. Mother's Name (First Maggie I	, Middle, Maiden Sui K <b>ing</b>	rname)
, Mary	1 and 2 shou Health and M tem 27 is mai other traumai	Ì	19a. Informant's Name/Relationship (Type. Print)  Connie A. Springer, daug	hter	9b. Mailing Address (Street 1195 Iron Spi	rings Road, 1	Fairfield,	, PA 17320
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		20a. Method of Disposition 1 ☐ Burial 2	State Source Car	e of Disposition (Name of ely, crematory or other place croll Cremator	ry 12/24/20	008 Wint	ion - City or Town, State
Ball	permit Depart Import any in		21. Signature of Funeral Service Licensee	woran	210 W Mair	n St, Emmitsk	ourg, MD 2	
	Physician		23a. Part1. Enter the disease, or complications that control shock, or heart failure. List only one cause on elimmediate Cause (Final disease or condition					Approximate Interval Between Onset and Death
( ) 	/Medical Examiner	iner	resulting in death)  Due to (  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  Due to (	or as a consequence of A O N N or as a consequence	RY ARTE	er DISE	ASE	
68760,	eath certificate be executed attending physician and for use as the burial-transit	dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last C	or as a consequenc	ce of):			
P.O. Box 6	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	23b. was decedent pregnant 1 Live b	come pf pregnancy irth 2  Fetal de ant at time of death own	ath 3 ☐ Ectopic pregnancy	,	23d	d. Date of delivery Month Day Year
rds, P	quires that n signed b uld be deta		Part II. Other significant conditions contributing to de	eath but not resulting	ig in the underlying cause giv	en in Part I. 2		contribute to the cause of death?  No 3 ☐ Probably 4 ☐ Unknown
or Vital Records,	The law rete has bee lage 2 shot	Completed by	HYPERIPIDE	510N MIA			4a. Was an 2 autopsy performed? ☐ Yes 2 No	24b. Were autopsy findings availabl prior to completion of cause of death? 1 □ Yes 2 ☑ No
r Vital	Physician: this certifica ral director, p	Be	25. Was case referred to medical examiner?  1 Yes 2 No Hospital: 1	npatient 2□ER/	/Outpatient 3 DOA Oth	26. Place of Death (Che	ck only one)	
Division o	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification: To	2 Accident investigation 3 Suicide 6 Could not be	of injury - At home	Bb. Time of Injury More More 1 (28c. Injury More More 1)  a, farm, street, factory, office	Yes 2 □ No 28f. Lo	pescribe how injury of the house of the hous	occurred Number or Rural Route Number,
ΡĮ	ospital or / hours after uneral Dire ly filled in b	al Certi	4 Homicide buildi  29a. Certifier   Certifying Physician: To the (Check only 2   Medical Examiner: On the buildi			me, date and place, and de		
	To the Hospital within 24 hours of To the Funeral completely filled	Medical	one) and man	ner stated.	000 Linear			signed (Month, Day, Year)
	117L		David S. M.	100 M	MD	0361685		22/2008

WJL 10

State Registrar

4910 A. FAIRFIELD RD. DAVID MOELE, M.D.
31. Date filed (Month, Day, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FAIRFIELD, PA.

17320

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2008 43083 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** John Alfred Shryock December 19, 2008 11:25 a<sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Taneytown Carroll 18 Broad Street | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year, Apr. 25, 19 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F 218-07-9529 93 Yrs. Director 1915 Maryland Usual Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heelth and Mental Hygiene. Important: If item 27 is marked other then "natural", or iteme 23a or 28a-1 ehow eny injury or other traumatic event, the Medical Examiner must be notitied at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Carroll Completed by Funeral Director Taneytown 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 18 Broad Street 21787 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 □ Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b. Kind of Business/Industry during most of working Elementary/Secondary (0-12) College (1-4or 5+) 10 Foundry Machinist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Harvey Shryock Bertha Stonesifer 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Yvonne Staub, daughter 6316 Taneytown Pike, Taneytown, MD 21787 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Keysville Union Cem | 12/23/2008 Keymar, MD 21. Signature / Funeral Service Licensee 22. Name and Address of Facility Myers-Durboraw Funeral Home 136 E Baltimore St, Taneytown, MD 21787 ann 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final CANCEZ 1705tate Physician disease or condition resulting in death) 10 years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to influe diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) ettending physicien and for use as the burial-transit Hospital or Attanding Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐ Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ NON INSULIN DEPENDENT Dicheles Be Completed 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed?
1 ☐ Yes 🎉 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificete has Director: After this certific I in by the funeral director. 25. Was case referred to medical 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death. To the Funeral Director: A completely filled in by the fu investigation 2 Accident 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) å 29b. Signature and title of certifier 2 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

WJL

6+1VA

K. Carlynn

32. Registrar's Signature

we some crea

Lomos

STUPER

DEC 2 2

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AUR

2008

031660

maruland

12/19/2008

THOMAS IL GALUN TY L

State of Maryland / Department of Health and Mental Hygiene 43084 1 - State Registrar/AMFND#7per/FH12/24/08, EMW, McCo Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Dorothy Settles Dec. 17, 6:40 P M 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** The Millennium of Forestville Forestville Prince Georges If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 □ M 2 T F 86 Months Days 213-24-3637 85 Director N/A March 12, Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 20. 4 any injury or other traumatic event. The Market any injury or other traumatic event. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1X Yes 2 □ No Washington, D. C. D.C. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 401 K Street, N. W. 20001 USA Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No Specify: Black Specify: 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Government Clerical 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Carrie Unknown William Hawkins ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Henry H. Cauthorne, Jr./Cousin | 9700 Wedgewood Dr., Ft. Washington, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Dec.27,2008Suitland, MD 4 ☐ Donation 5 ☐ Other (Specify) Washington National 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Latney's Funeral Home 3831 Georgia Ave., NW Washington, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cardiopulmonary Failure /Medical Due to (or as a consequence of): Examiner Coronary Artery Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Hypertension Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 ☐ Other (specify) 9 Hinknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>چ</u> Congestive Heart Failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 € Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? Chronic Renal Disease 24a. Was an autopsy perform 1 ☐Yes 2 ☐ No 1∐Yes 2√121No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 🖾 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending Injury 1 ☐Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 51520 Dec. 23,2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bahram Pishdad, MD 1328 Southern Ave. SE Washington, D.C. 20032 31. Date filed (Month, Day, Year) Registrar's Signature State DEC 2 4 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar MEND#24a+boerMD, 12/24/08, EWW, MoCo Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) December 79, 2008 1215 A M **Physician** W. Spaulding Marjorie /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Frederick Frederick Crumland Farms Health Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 008-12-8224 1 M 2 XF 86 Director May 13, 1922 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 X Yes 2 □ No Director Frederick Frederick 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 21701 9 Kline Blvd Funeral 12. Was Decedent Ever in U.S. Armed Forcea? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □ Yes 2 No White Maryland 21215-0036 Specify: 3 Widowed 4 □ Divorced Completed by 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Registar Education permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: If Item 27 is marked other any Injury or other traumatic event. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna Irene Moore Arthur E. Williams 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shelley Johnson - Daughter 9 Kline Blvd Frederick MD 21701 3altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) National Crematory 12/21/08 Falls Church, VA 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Edward Sagel Funeral Direction Inc 1099 Rockville Pike Rockville MD 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) いいけんく Physician 90141 /Medical Du lo (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requires that the death certificate be executed burial-trar Due to (or as a consequence of): physician sthe burial Box 68760 Physician/Medical as for use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 Yes No 3 Probably 4 Unknown p-ge 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a Was an autopsy performed? 1∐ Yes 2 No Vital 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 ER/Outpatient 3 DOA 은 1 Inpatient ▶ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 0 this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? e Hospital or Attending PI 124 hours after death. e Funeral Director; After the letely filled in by the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Medical Certification: Division Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or A within 24 hours after to the Funeral Director Completely filled in b artifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

State Registrar 31. Date filed (Month, Day, Year) 24 2008 DEC

29b. Signature and





PINJAICLANS as:

29c. License number

29d. Date signed (Month, Day, Year)

10

			State of Maryland	-	rtment of F tificate of			000	0 10000
	_		Registrar  1. Decedent's Name (First, Middle, Last)		uncate or i	Dealli	2. Date of Deat	eg. No. Z	3. Time of Death
П	Physici		William Claude Tuthill				Month	Day Yea er 20, 20	r
and the second	/Medic Examir		4a. Facility Name (If not institution, give street and number)		4b. City, Town, o	r Location of Death		eath	
my de			2010 Quebec Street		Adelphi If Under 1 Year	If Under 24 Hrs	0.0.1.10111		e George's
L	Funeral Director		5. Social Security Number 395-12-2409 6. Sex 1X M 2 □ F 7. Age (In yrs. las	st birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Sept • 28	, 1923 W	Birthplace (State or Foreign Country) ISCONSIN
	land ow		Usual Residence of Decedent  10a. State 10b. County 10c. City,	Town or Loc	cation		`		10d. Inside City Limits
	Mary a-f sh	tor	Maryland Prince George's	Adelp1	hi				1 ☐ Yes 2 🙀 No
	or 28%	Directo	10e. Street and Number		10f. Zip Code		10	Og. Citizen of What (	Country?
	ath wi		2010 Quebec Street		20783			USA	
36	be filed within 72 hours after death with the Maryland rital Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Mcdicol Evar, the Frust be notified at	by Funeral	11. Marital Status  1 ☐ Never Married 2. □ Married  3 ☐ Widowed 4 ☐ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1. □ Yes 2 ☐ No If Yes, Give Year or Dates: 1943—	1	Vas Decedent of H Yes, specify Cuba ☐Yes 2IX No	lispanic Origin? (Spe an, Mexican, Puerto Specity:	ecify Yes or No- Rican, etc.)	14. Race - Ar Black, Wh Specif <b>Whi</b>	
5-0036	2 hou latura ical E		15. Decedent's Education	16a. Deced	ent's Usual Occup	ation	Ţ,	16b. Kind of Busines	1.01.11
	ithin 7 ne. nan "r	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)			during most of worki	I .		
2	Hygier Hygier Ather th		12 17. Father's Name (First, Middle, Last)	Phar	macy Tec	hnician  18. Mother's Name		.S.Milita	ry
ano	ould be f Mental I arked of atic eve	To Be	Addison C. Tuthill				rene You	ŕ	
Maryland 2121	2 should be filed and Mental Hygi and Mental Hygi Is marked other aumatic event, I	۴	19a. Informant's Name/Relationship (Type. Print)	19b. Mailin	g Address (Street	and Number or Rura	al Route Number,	City or Town, State	, Zip Code)
Σ,	and 2 lealth a m 27 Is her tra		Anna Tuthill/Wife	20	10 Quebe	c Street,	Adelphi	, MD 2078	33
Baltimore,	of ite		14 Burial 2 Cremation 3 Removal from State	netery, cřem	sition (Name of latory or other place n Nat'l	and I	an. 8,	20c. Location - City of arlington,	or Town, State  Virginia
Balt	permit. Page Department of Important; If any Injury or once.		21. Signature of Funeral Service Licensee					Home Inc	:. :ing, MD 2090:
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Acute Myeloid  Due to (or as a consequence)	Do not ente	er the mode of dyin				Approximate Interval Between Onset and Death 2 years
		Examiner	Sequentially list conditions, it any leading to him models cause. Enter Underlying Cause, (Disease or injury)	ic Sy	ndrome				
) _^	ificate be executed g physician and ss the burial-transit	xan	that initiated events resulting in death) Last C	nce of):					
09/89	ysicial	edical	d						
_		Medi	IF FEMALE:						
O. Box	the death certific y the attending p ched for use as t	Physician/M	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnanc 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of dea	leath 3 🗌	Ectopic pregnancy Other (specify)	у		23d. Date of d Month	elivery Day Year
rds, P.	law requires that the de as been signed by the 2 should be detached	ρχ	Part II. Other significant conditions contributing to death but not resulting Hypertension, Glaucoma	ng in the und	derlying cause give	en in Part I.			to the cause of death?
ပ္က	law rec as bee 2 shou	olete					24a. Was an		autopsy findings available
	The ate h	e Completed	25. Was case referred to medical			26. Place of Death	autopsy perform	ed? death? ☑No 1 ☐ Ye	completion of cause of es 2 □ No
<u> </u>	Physician: r this certific ral director, I	10 B	examiner? 1 ☐ Yes 2 ☑ No	R/Outpatient	3 □ DOA Othe			nce 6 ⊡Other <i>(Sp</i>	pecify)
on or	nding PI tth. :: After tl e funeral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation 28a. Date of Injury (Month, Day, Year) 28	8b. Time of Injury	28c. Injury Work		28d. Describe hov		
DIVISION	To the Hospital or Attending Physician: within 24 hours after deals. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home building, etc. (Specify)	e, farm, stre	et, factory, office	2	28f. Location (Stre City or Town,	eet and Number or I State)	Rural Route Number,
	he Hospii in 24 hour he Funera pletely filli	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowle 2 Medical Examiner: On the basis of examination and manner stated.	edge, death n and/or inv	occurred at the tin estigation, in my o	ne, date and place, pinion, death occurr	and due to the ca ed at the time, da	use(s) and manner te and place, and du	as stated. ue to the cause(s)
	10 + (	Ž	29b. Signature and the of certifier	5	29c. License	D10198	29 D	d. Date signed (Mor December 2	nth, Day, Year) 23, 2008
	10		30. Name and address of person who completed cause of death (Item 23 Edward M. Buda, MD 6900 Georg	3a)(Type,P	rint) enue, NW	, Washing	ton, DC	20307	
	Sta Registr		31. Date filed (Month, Day, Year)  DEC 2 4 2008  32 egistrar's Signatur	e de	W.				

State of Maryland / Department of Health and Mental Hygiene 2008 43087

		1	For State Registrar	Co	ertificate of E	Death	Reg.		9 43001
Phys	icia	n	1. Decedent's Name (First, Middle, Last)	3				Day Year	3. Time of Death
/Me Exai	edica mine		a. Facility Name (If not institution, give street and r		4b. City, Town, or		Dec.18	4c. County of Deat	
			Laurel Regional Hos  5. Social Security Number   6. Sex	spital 7. Age (In yrs. last birthda	Laure I	If Under 24 Hrs.	8. Date of Birth	9. Birt	Georges  hplace (State or Foreign
Fune Direct			491-13-2157 1☑ M 2□F	53 Yrs.	Months Days	Hours Min.	(Month, Day, Ye 9 / 27 / 19	55 C	untry) uba
land ow	į.		Usual Residence of Decedent  10a. State 10b. County Montgomery	10c. City, Town or	Location				10d. Inside City Limits
e Mary Ba-f sh		ctor		Silver	Spring				1 ☐ Yes 2 X No
th with th		Funeral Director	10e. Street and Number 504 Domer Avenue	Apt.203	10f. Zip Code 2091			Citizen of What Co	untry?
ING 21215-UU36 be filed/within 72 hours after death with the Maryland tial Hygiene. the Hydiene. the folder than "natural", or items 23a or 28a-1 show event.		2	Armed	: 21€ No	3. Was Decedent of Hi If Yes, specify Cubar 1 ☑ Yes 2 ☐ No			14. Race - Ame Black, White Specify: W	
10 Z1Z15-UU36 if fledwithin 72 hours aff al Hygiene. other than "natural", or		Be Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College	(Gi	cedent's Usual Occupa ve kind of work done d b. DO NOT use retired; nemployed	luring most of work )	ing 16b	none	Industry
Illedwi		5	17. Father's Name (First, Middle, Last)	u.			e (First, Middle, Maid		
Taryland 2 should be to and Mental Is marked or	ľ	o O	Juan Valdez			Franci	sca Tori	res	
2 75/4	4		19a. Informant's Name/Relationship (Type. Print)  Vanessa Valdez/Daud		ailing Address <i>(Street a</i> 326 Evans				
a a a a a a a a a a a a a a a a a a a		ŀ	20a. Method of Disposition	20b. Place of Dis	sposition (Name of rematory or other place	e)	Date 200	. Location - City or	Town, State
baltimore, permit. Pages 1 ar Department of Hea Important: If item 3			1 🛱 Burial 2 □ Cremation 3 □ Removal from 4 □ Donation 👂 □ Other (Specify)	Gate Gate	of Heave	n 12/2			Spring,Md
Departmine Department of the popular	once		21. Signature Wineral Service Lice Lee		PHYMETPACES 9241 Colu	RTNALDI umbia BI	FUNERAL vd.Silve	L SERVIC er Sprin	E,P.A. ng,Md20910
			23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause or	t caused the death. Do not deach line.	enter the mode of dying	g, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
Physicia /Medic	_	1	reculting in death)	rdio pumono (or as a consequence of):	ary arres	st			
Examin	•		Δα	cute myocar	dio infar	ction			
tuted d		Examiner	cause. Enter Underlying	abetes mel	litus				
icate be executed physician and the burial-transit		Exa	resulting in death) Last Due t	o (or as a consequence of):					
<b>58 / 5U,</b> tificate be example of physician as the burial		Medical	d						· · · · · · · · · · · · · · · · · · ·
death cer e attendired for use		Physician/M	in the past 12 months?	gnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	/		23d. Date of del Month	ivery Day Year
rattl d by		by Ph	Part II. Other significant conditions contributing to	death but not resulting in the	e underlying cause give	en in Part I.	23e. Did tobac	co use contribute to	the cause of death?
Ords requires een sig					<del></del>		1 ☐ Yes	2 No 3 Pr	robably 4 🗌 Unknown
The lay ate has		Completed					24a. Was an autopsy performed 1 □Yes 2 ₹	prior to death?	itopsy findings available completion of cause of 2 □No
VISION OT VITAI Attending Physician: T or death. ector: After this certifical by the funeral director, pa		o Be	25. Was case referred to medical examiner?  Yes 2 □ No Hospital: 11	☐ Inpatient 2 AER/Outpa	tient 3 DOA Othe		h (Check only one) ome 5 Residence	o 6 DOthor (See	oifu)
		- 1		te of Injury 28b. Time Injury Injury	e of 28c. Injury		28d. Describe how i		City)
DIVISION I or Attending after death. Director: After		catio	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	ce of Injury - At home, farm,		Yes 2□No	28f. Location (Stree	t and Number or Ri	ural Route Number
DIV salor A safter al Direct ed in by		Certification:	4 Homicide determined bu	Iding, etc. (Specify)	on out indicately, and		City or Town, S	itate)	arar riodio riaribor,
DIVIS  e Hospital or Att. 24 hours after de Funeral Directo	: 1	edical (	29a. Certifier 1 Certifying Physician: To (Check only one) and m	he best of my knowledge, do basis of examination and/o anner stated.	eath occurred at the tin r investigation, in my o	ne, date and place pinion, death occu	, and due to the caus rred at the time, date	se(s) and manner as and place, and due	s stated. e to the cause(s)
To the Hosp within 24 hor To the Fune		Med	29b. Signature and attle of certifier		29c. License	e number	29d.	Date signed (Mont	h, Day, Year)
1			, fume	M-D		16952		12/18/08	3
,			30. Name and add as of person who completed of	tuse of death (Item 23a) (Type 15)	001 Healt	h Cente	er Dr.Bov	wie ,Md	20716
Poo	Stat	e		Registrar's Signature	Berlin .	-			

DHMH 17 Rev 1/2001

1.3000

Physician	
/Medical	
Examiner	

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examination that to notified at once.

Baltimore, Maryland 21215-0036

**Physician** /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760, DB 10 State

	Registrar	Cer	tificate of I	Death	Reg.	No. 2 U U O	43000					
1. Decedent's Name (First, Middle, Last)  2. Date of Death  Nonth Month DECEMBER 20, 2008  1. Decedent's Name (First, Middle, Last)  2. Date of Death  DECEMBER 20, 2008  1. Date of Death  1. Decedent's Name (First, Middle, Last)												
	HELEN ELIZABETH TURNER				DECEMBER 20, 2008 1334							
	4a. Facility Name (If not institution, give street and number, SOUTHERN MARYLAND HOSPITAL			Location of Death	4c. County of Death PRINCE GEORGES							
	5. Social Security Number 6. Sex 7. As	ge (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birthp 6,1938 MAR	lace (State or Foreign					
	216-40-9563	70 Yrs.	Wortens Baye	Tiours Inni	AUGUST"1	6,1938 MAR	YLAND					
	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Loc	ation			110	Od. Inside City Limits					
5			ation				1 TyYes 2 □ No					
200	MARYLAND CHARLES	LA PLATA	105 7in Codo		100	. Citizen of What Coun	Λ					
5	10e. Street and Number		10f. Zip Code	0646		NITED STAT	•					
2	909 LAUREL LANE	Everin II C 12 14				14. Race - Americ						
5	11. Marital Status  1 X Never Married 2 ☐ Married  12. Was Decedent Armed Forces 1 ☐ Yes 2 X	No		lispanic Origin? (Span, Mexican, Puerto	Rican, etc.)	Black, White,						
D.	If Yes, Give  3 □ Widowed 4 □ Divorced Year or Dates:	1	□Yes 2 📈 o	Specify:		Specify: BL	ACK					
חובובת	15. Decedent's Education	16a. Deced	ent's Usual Occup	ation	161	b. Kind of Business/Inc	lustry					
2	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or	(Give k	rind of work done of NOT use retired	during most of worki	ing							
5	4 YEARS	LAB	TECHNIC	LAN	F	EDERAL GOV	ERNMENT					
2	17. Father's Name (First, Middle, Last)				e (First, Middle, Mai		<b>.</b>					
2	ROBERT LEO TURNER			MARY ELL	ZABETH JO	RDAN TURNE	K					
	19a. Informant's Name/Relationship (Type. Print)	1	,			ity or Town, State, Zip						
	TYRONE I. TURNER, JR./GRAN			-	ATA, MARY							
	20a. Method of Disposition 1 □	20b. Place of Dispos cemetery, crem	sition ( <i>Name</i> of eatory or other place	ce)		PORT TOBA						
	4 □ Donation 5 □ Other (Specify)					PURI TUDA	CCO, MD					
	21. Sit ature of Funeval Service License LYDIA C. THORNTON JOHNS	ON MOO583	HORNTON	ss of Facility FUNERAL H	OME, P.A.	N IIIIAD MA	DVI AND 2001					
Evalunci	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	d the death. Do not enterine.  RTENSI s a consequence of): s a consequence of): s a consequence of):					Approximate Interval Between Onset and Death					
ealcai	d			·								
nysicial vive		2 Fetal death 3	Ectopic pregnand Other (specify)	у		23d. Date of delivery Month Day Year						
_	Part II. Other significant conditions contributing to death	but not resulting in the un	derlying cause giv	en in Part I.	23e. Did tobac	co use contribute to the	ne cause of death?					
2	HYPERTENSUN	KION	EY FA	<i>filure</i>	. 1 ☐ Yes	2 No 3 Prob	ably 4 Unknown					
completed by	MELITUS	ty DIA	BETE	5	24a. Was an autopsy performe	d?   death?	psy findings available mpletion of cause of					
b	25. Was case referred to medical		· · · · · · · · · · · · · · · · · · ·	26. Place of Deat	1 ☐ Yes 2 h h (Check only one)	No 1 □Yes	∠ □ INO					
ב	examiner? 1 Yes 2 No Hospital: 1 Mapat	ient 2 🗌 ER/Outpatien	t 3 DOA Oth	or:		e 6 ∏Other (Specif	v)					
27. Manner Death 1												
29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.												
N N	29b. Signature and title of certifier		29c. Licens	se number	29d	. Date signed (Month,	Day, Year)					
	ATTEAN	WG-PHYSIC	LANU D	52900	)   1	2-21-21	008					
	30. Name and address of person who completed cause of			4.201	1 1400	2-21-21 16R MD	20705					
	31. Date filed (Month, Day, Year) 32. Regis	trar's Signature	AL RV	#30l,	LANDA	AC MID	20/85					
	DEC 2 3 2008	ELLE ST B	poster?									

Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 20, December 12:45 P M Jennie Thompson 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Calvert Solomons Asbury Health Care Center 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 1 □ M 3 □ X F 81 Months Days Hours Min. 224 32 7852 1927 July 12, Virgínia Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a. State 1 □Yes ŽŽNo Maryland Calvert Solomons 10f. Zip Code 20688 10e. Street and Number 10g. Citizen of What Country? 11750 Asbury Circle United States 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: White Specify. 3 ☐ Widowed 4 🎇 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mayo Snowden Janssen Dewilton Snowden 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth J. Thompson (Daughter) 53 Millbridge Court, Baltimore, MD 21236 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Lee Crematory Dec 22, 2008 Clinton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d 21. Signature of Smeral Solvice Alexandria Ferry Road, Clinton, MD 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 5 TAGE CHRUNE OBSTRUCTIVE PULMONACT DISPASE END Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 XXNo Month Day Year 5 ☐ Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? HEART FAILURE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown DARIVE AILURE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perfori 1 □ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 INO 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 No 2 ☐ Accident 6 ☐ Could not be

Examiner law requires that the death certificate be executed burial-transi and Box 68760, attending physician for use as the burial signed by the a P.0. of Vital Records, been page 2 s Physician: director, spital or Attending Division

Examiner Physician/Medical þ Completed After this certificate has Be Certification: To funeral hours after death.

Ineral Director: Af
Ily filled in by the fur Medical

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

þ

Completed

Be

၉

permit, Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.

Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It of Poster Examiner must be rediffed an once.

**Physician** 

/Medical

Baltimore, Maryland 21215-0036

	To the Ho	within 24	To the Fu	completel
		_	_	
1	P	) [	Ď	

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

determined

1 Pritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

D26358

2008 10-6-22

28f. Location (Street and Number or Rural Route Number, City or Town, State)

John H. Weigel, MD 120 Hospital Road Prince Frederick, MD 20678

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

32. Registrar's Signature DEC 2 2008

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Moderal Experiment must be redified at ange. Baltimore, Maryland 21215-0036 Physician /Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

Physicia /Medica Examine

Funeral Director

	1 - State of Marylan State of Marylan Registrar		tificate of D		тептат нус	eg. No.2008	3 43090							
	1. Decedent's Name (First, Middle, Last)				Date of Dea     Month	Day Yea	3. Time of Death							
al a	Rosa Mercedes Vegarra				Decembe	er 22, 200								
r	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or L			4c. County of De								
H	Suburban Hospital  5. Social Security Number   6. Sex   7. Age (In yrs. )	last hirthday)	Bethesda If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Montgomery  f Birth 9. Birthplace (State or								
	217-27-6228 <sup>1□ M 2</sup> F 76	Yrs.	Months Days	Hours Min.	(Month, Day Sept. 4	, Year) 1, 1932	Birthplace (State or Foreign Country) Peru							
	Usual Residence of Decedent  10a. State 10b. County 10c. Cit	y, Town or Loc	ocation 10d. Inside City Lim											
ō	Maryland Montgomery	Si	lver Sprin	na			1 □Yes 2 🔀 No							
rec	10e. Street and Number		10f. Zip Code	19		log. Citizen of What	Country?							
<u>a</u>	13615 Montvale Drive		20904		Peruvi	an								
Funeral Director	11. Marital Status 12. Was Decedent Ever in U. Armed Forces?	S. 13. V	Vas Decedent of His Yes, specify Cuban	panic Origin? (Spe Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ar Black, Wh	merican Indian,							
	1 ☐ Never Married 2 ★★ Married 1 ☐ Yes 2 ★ No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:		Tyes 2□No		ruvian	Specify:	White							
Completed by	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	lent's Usual Occupat kind of work done du	tion	na	16b. Kind of Busines	ss/Industry							
nple	Elementary/Secondary (0-12) College (1-4or 5+)	life. E	OO NOT use retired)	ing most or work	rig									
် ပ	12	Home	emaker	10. 14-11	(First Middle	Own	Home							
Be	17. Father's Name (First, Middle, Last)		'			Maiden Surname)								
9	Milciades Bocanegra	10h Mailin	a Address (Street or		sca Luja	r, City or Town, State	Zin Codo)							
	19a. Informant's Name/Relationship (Type. Print) German A. Vegarra/Son	1	•			ton, DC 2								
	1 Burial 2XXCremation 3 Hemoval from State		sition (Name of natory or other place, itan Crema	. i De	ec. 29,	20c. Location - City  Alexandr	or Town, State							
	21. Signature of Funeral Service Licensee	22 <b>F</b> 3	Name and Address	of Facility Collins	Funeral	. Home Inc								
	23a. Part 1. Enter the disease, or complications that caused the death	Approximate												
	23a. Part 1. Enter the isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):													
	Due to (or as a consequence of):													
ē	Sequentially list conditions, if any, leading to immediate  b. Granulogator  Due to (or as a consequence)				2 years									
Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  b. Granul Omato:  Due to (or as a consequence of the condition					6								
Exa	resulting in death) Last  Due to (or as a consequence)	uence of):			·	6 years								
edical	d													
	IF FFMAI S				- 27   - 2									
Be Completed by Physician/M	23b. Was decedent pregnant in the past 12 months?	in the past 12 months?  1												
V Ph	Part II. Other significant conditions contributing to death but not resu	ulting in the un	derlying cause giver	n in Part I.	23e. Did to	bacco use contribute	to the cause of death?							
ed b	Diabetes Mellitus, Type II				1 □ Y	es 2⊠ No 3□	Probably 4 🗍 Unknown							
plet	Hypertension		· · · · · · · · · · · · · · · · · · ·		24a. Was a		autopsy findings available to completion of cause of							
0	Dyslipidemia				perfor	med? death	? es 2⊡No							
Be	25. Was case referred to medical examiner?			26. Place of Death	(Check only or	ne)								
0	1 ☐ Yes 2 ☑ No Hospital: 1 ☑ Inpatient 2 ☐	<u>.</u>		4 LINUISHING HO		ence 6 ☐ Other (S	pecify)							
ion:	27. Manner of Death 28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury Work? M 1 4		28d. Describe h	ow injury occurred								
icat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At ho	me farm etre	1,111	es 2□No	28f Location (S	treat and Number or	Rural Route Number,							
er#	4 Homicide determined 200, Flace of Injury - Article building, etc. (Specific	y)	set, lactory, office		City or Tow	n, State)	rtural moute rvumber,							
ٽ ھ	29a. Certifier 1X CertifyIng Physician: To the best of my kno	wledge, death	occurred at the time	e, date and place,	and due to the	cause(s) and manner	as stated.							
edical Certification:	(Check only one) 2 Medical Examiner: On the basis of examina and manner stated.													
Me	29b. Signature and title of cartifier		29c. License	number	2	29d. Date signed (Mo	onth, Day, Year)							
	Vischolo2		D551	152	December 24, 2008									
	30. Name and addless of person who completed cause of death (Item	23a) (Type, I	(Type, Print)											
	Gino Mendoza, MD 4701 Rando		ad, #216,	Rockvill	e, MD 2	0852								
e	31. Date filed (Month, Day, Year)  DEC 26 2008 32. Registrar's Signa	ture												
-	The state of the s	S. S. S.	Battle											

Stat Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar amend item 6 perfhbb 12-29-08ertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** KATHERINE /Medical 2009 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 → M 2√ F Months 215 52 6698 56 May1,1952 Maryland Director Usual Residence of Decedent 10d. Inside City Limits if than "natural", or items 23a or 28a-f show the Medical Experient regat be notified at 10a. State 10b. County 10c. City. Town or Location 1 ☐ Yes 2 ☐ No Director Maryland Montgomery Germantown the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 11524 Doxdam Terrace 20876 US Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 XNo Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Sales Private traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mental and 2 should be h and Mental 7 is marked o Bernard L. Wright, Sr. Katherine Brown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health item 27 i 11524 Doxdam Terrace Germantown, MD 20876 ace of Disposition (Name of Date 20c. Location - City or Town, State Melissa Voigt/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of Important: If it any Injury or o oonce. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Riverdale Crematory 12-24-08 Riverdale, Md 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility BRISCOE-TONIC FUNERAL HOME 21. Signature of Funeral Service Licensee, F MD20601
Approximate
Interval Between
Onset and Death 2294 Old Washington Road Waldorf e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23a. Part 1. Enter the disease shock, or heart failure. Immediate Cause (Final **Physician** disease or condition resulting in death) PREUMONIA -121ci11/15 /Medical Due to (or as a consequence of) Examiner 9-Mowitts MORUERIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine il or Attending Physician: The law requires that the death certificate be executed after death. attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year 5 Other (specify) P.O. been signed by the s should be detached f 1 ☐ Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ≥ 1 ☐ Yes 2 Mo 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No page 2 s autopsy performed? certificate To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide e Hospital of 24 hours at e Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. To the I within 2 To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 861531899

State

Registrar

BALTIMERE MID

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

32. Registrar's Signature

6:145

DEC 23

31. Date filed (Month, Day, Year)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Physician 2008 December 22 7:58 PM Esther Hopkins Vetra /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Wicomico Nursing Home Salisbury Wicomico If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 1 □ M 2 🗙 F 86 July 17, 1922 Maryland 214-12-5447 Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits 10a State 10b. County 1 □Yes 2 N No Director Delmar MD Wicomico 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? 21875 31965 Downing Road U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black White etc. 1 Never Married 2 Married 1 ∐Yes 2. If Yes, Give Year or Dates: 2 No white 1 ☐ Yes 2 🖾 No Specify: Specify ģ 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Licensed Practical Nursing Hospital 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert Wesley Hopkins Catherine Bozman P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Valerie Lingle (Daughter) 31965 Downing Road Delmar, MD21875 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Stephens Cemetery 12-29-2008 Delmar, Delaware 22. Name and Address of Facility Short Funeral Home 21. Signature of Funeral Service Licensee 13 E. Grove Street DEDelmar, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final TERISCLE MOTI disease or condition resulting in death) Due to (or as a consequence of) Se juentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Conknown Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1∐ Yes

**Physician** /Medical Examiner

**Funeral** 

Director

attending physician and for use as the burial-trar signed by the a

The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

Completed by

Be မှ After thi funeral Certification:

To the Hospital or Attending Physician: within 24 hours after control to the Funeral Director: Aft " HN

State Registrar

25. Was case referred to medical examiner?

1 ☐ Yes 2 No 27. Man r of Death 1 Natural 2 Accident 3 ☐ Suicide

4 Homicide

(Check only

29b. Signature and title of certifier

29a. Certifier

one)

5 ☐ Pending investigation 6 ☐ Could not be determined

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

mund 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mahesha Thimmarayappa M.D. 614 Easternshore Dr Salisbury MD 21804 31. Date filed (Month, Day, Year) 2008

9

32. Redistrar's Signature

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. amend item#21perFH, G887/1/12/09, WS State of Maryland/ Department of Health and Mental Hygiene 1 - For State Registrar Reg. No 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** F VanDyKe Kobert 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary St. Mary MD tospita Leonardtown rear If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Y 7. Age (In yrs. last birthday) 9. Birthpla **Funeral** e (State or Foreign Months Days 1 X M 2□ F 016287284 Yrs Director 74 OCT.28,1934 MASSACHUSETTS Usual Residence of Decedent 10a, State 10h County 10c. City. Town or Location 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Exercising the country of the country o Director Yes 2□ No ST. MARY'S MD LEONARDTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21585 PEABODY STREET 20650 U. S. A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1. ☐ Yes 2 ☐ No If Yes, Give Year or Dates:1963 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: 2 Specify: 3 Widowed 4 Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 STEAMFITTER STEAMFITTERS UNION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ PERCY J. VAN DYKE SR. MADELINE LOUISE MAGUIRE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sl Department of Health an Important: If item 27 is n any Injury or other traur THERESA DEMMICK/DAUGHTER 7521 MONROE DR. KING GEORGE, VA 22485 Baltimore, 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🙀 Cremation 3 ☐ Removal from State DECEMBER 4 ☐ Donation 5 ☐ Other (Specify) METROPOLITAN CR. 28,2008 ALEXANDRIA, VA 21. Signature of Funeral Service Licensee M00641 22. Name and Address of Facility RAYMOND FUNL.SERVICE, P.A. M00641 5635 WASHINGTON AVE., LA PLATA, MD 20646 Joseph Barton Yates 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of pach line. Approximate Interval Between Onset and Death Immediate Cause (Final neumonia **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner physician and s the burial-trans Due to (or as a consequence of) P.O. Box 68760, Physician/Medical X19 as attending IF FEMALE: use ( 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 1 ☐ Live birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown 3 Ectopic pregnancy po in the past 12 months? Month Day Year 5 ☐ Other (specify) the 1 Tyes 2 No. 9 Unknown s been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ 1 □ Yes 3 □ 24a. Was an page 2 autonsy certificate 1 □Yes 2 1 No Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1∐Yes 2thNo 2 ER/Outpatient 3 DOA Medical Certification: To this After th funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Hospital or Attending 5 Pending investigation 1 Naturai death. 2 Accident 1 ☐ Yes 2 ☐ No after death Director: A 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours after
To the Funeral Dire
completely filled in b 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and the o 29d. Date signed (Month, Day, Year) ertifier 29c. License number 12-23-08 30. Name and addres f person who completed cause of death (Item 23a) (Type, Print) MANOJ D. PANWALA, M.D. 37767 MARKET DR. 2nd FL.C!HARLOTTE HALL,MD20622 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2009 Registrar

DHMH 17 Rev 1/2001

Registrar DHMH 17 Rev 1/2001

State

30. Name and address of person who completed cau-

Anushiravan Dadgar,

31. Date filed (Month Lay,

Division of Vital Records, P.O. Box 68760.

of death (Item)23a) (Type, Print)

egistrar's Signature

MD

2008

140051280

10110 Molecular Drive, Rockville MD 20850

12-24-4000

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registra AMEND#17perFH, 1-6-09, BWW, McCo Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death December 18, 2008 **Physician** Charles Leonard Witt 10:50p<sub>M</sub> /Medical 4a. Facility Name (If not institution, give street and number)
Prince Georges Hospital Center 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Cheverly 7. Age (In yrs. last birthday) 73 vrs If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea April 12, 6. Sex 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Year) 1935 Days Hours West Virginia Min. 1**№**M 2□F 232-50-6719 Director Usual Residence of Decedent ages 1 and 2 should be filed within 72 hours after death with the Maryland int of Health and Mental Hygiene.

If Item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event. 10c. City, Town or Location Rainer 10b. Count 10d. Inside City Limits Prince Georges MD 1 KrYes 2 □ No Director 10g. Citizen of What Country? 10e. Street and Number 20712 United States 32nd Street 4522 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: δ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Metro Elementary/Secondary (0-12) College (1-4or 5+) Bus Driver 12th 17. Father's Name (First, Middle, Last) Charles Edwards Witt 18. Mother's Name (First, Middle, Maiden Surname)

Lucy Miller Be Charles Edwards Lucy ၉ 19a. Informant's Name/Relationship (Type. Print)
Lilly M. Collins (sister) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town State, Zin Code)
P.O. Box 251, Montgomery, West Virginia 25136 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Itel
any Injury or ott 1 Burial 2 ☐ Cremation 3 Femoval from State Ingram Branch, WVA 12/27/2008 Meadow Haven Mem. 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility McGuire Funeral Service, Inc. 7400 Georgia Avenue, NW, Washington DC 20012 of Funeral Service Licensee 22. Name and Address of Facility cholre Mong 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Myocardial Infarction Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Severe Anemia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): law requires that the death certificate be executed Metastatic Carcinoma sician and burial-trans Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 ☐ Pregnant at time of death 5 Other (specify) signed by the a d be detached f P.O. 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy Hospital or Attending Physician: The certificate 1 ☐ Yes 2 🔀 No 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2¥ No 1 ☐ Inpatient 2 A ER/Outpatient 3 ☐ DOA this Medical Certification: To After th funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural Injury thours after death.
uneral Director; Aftely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Vithin 24 hours after worthin 24 hours after worthin 24 hours after worthin 24 hours after worthin by 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year)

DEC

24

2008

DHMH 17 Rev 1/2001

HOSPITAL

Registrar's Signature

Cheverly MD

and address of person who completed cause of death (Item 23a)/(Type, Print) 3001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 43096 Reg. No 2008 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician December 21, 2008 6:25 P Eugene Paul Wilson /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner St. Mary's Charlotte Hall Veterans' Charlotte Hall Home If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | Sept. 1, 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 6. Sex 1 M 2 □ F **Funeral** Mary land 1937 Director 220-32-6232 71 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinating the Inclined at any injury or other traumatic event, the Medical Examination in traumatic event, the Medical Examination of the open. 10b. County 10c. City, Town or Location Director 1 □ Yes 2 No Maryland | Prince Georges Accokeek 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14811 Fort Trail 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2 X No Specify: ⋛ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) US Marine Corps Sargent 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Buchanan Wilson Pauline Deliah Evans 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 48020 Compass Circle #106, Lexington Park, MD. 20653 <u>Daniel S. Wilson</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🛱 Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Vets. Cemetery Dec.30, 2008 Cheltenham, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Huntt Funeral Home 21. Signature of Funeral Service License nwa 3035 Old Washington, Rd. Waldorf, MD. 20601 MØ 1190 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final **Physician** ALZHEIME disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) a Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
24 hours after death.
Purpose After this certificate has been signed by the attending physician and letely filled in by the funeral director, page 2 should be detached for use as the burst-transit Due to (or as a consequence of): Box 68760 Be Completed by Physician/Medical IF FEMALE yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.0. 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 - No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifiei and manner stated. To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D67788 12.22.2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ,2944 Charlotte Hall Rd., Charlotte Hall, MD. 20622 RAO KODALI 32. Registrar's Signature 31. Date filed (Month, Day, Year) State **DEC 23** 2008 Registrar

				icas										Apptol L		_	ible.	•	
	1	For State Registrar			3	iale (	) Mar	ylan		rtificat				Mental H	Reg. No		08	430	197
sician	1	I. Decedent's N		Middle,	Last)									2. Date of I		у	Year	3. Time o	f Death
edical	L	Alma	М.		nner									Decemb				11:10	) A <sup>M</sup>
miner		a. Facility Name			•							Location					ty of Dea		
		Citizen . Social Securit			nd R∈ 6. Sex	ehabi			n Cent ast birthday,			rick If Under		8. Date of E	Rirth		der		or Foreian
tor		216-52-	5916			2 💢 F	l	102	Yrs.	Months	Days	Hours	Min.	AUG. 3	0, Year)	06	Mar	irthplace (State Country) Syland	
	$\vdash$	Jsual Residence  0a. State	10b. C		_		1	10c. City	, Town or Lo	ocation								10d. Inside C	ity Limits
ţ		Marylan	ıd Fr	ede	rick			Fr	ederi	ck								1X Yes	2 🗆 No
any injury or other traumatic event, tractical parties of the source.  To Be Completed by Funeral Director	<u> </u>	0e. Street and							34022	10f. Zip	Code				10g. Cit	izen of	What C	ountry?	
		908	Semi	ino1	e R	d.					2170	1			Ur	rite	ed S	tates	
Funeral	1	1. Marital Statu	IS			Armed F	edent Ev		S. 13.	Was Deced	dent of Hi	spanic Oi n, Mexica	rigin? (Sp	ecify Yes or I	No-		ace - Am	nerican Indian,	
by Ft		1 Never M				If Yes, G		)		1 □ Yes		Specify		,		Spec		White	
d be		3 X Widowe			s Education	Year or [	Dates:		16a Dece	dent's Usu	al Occupa	ation			16h K	ind of I	Rusines	s/Industry	
Completed	-		pecify only	highesi	t grade co	mpleted)			(Give	kind of wo	rk done a se retired	luring mos	st of work	ing	100. 1	ilia oi i	20011100	3/11/du3ti <b>y</b>	
m o		Elementary/S	econdary (0	)-12)		College (	(1-4or 5+)	'	Ho	nemak	er				OW	ı 1	iome		
Be	1	17. Father's Nar	ne (First, M	liddle, L	.ast)							18. Moth	er's Nam	e (First, Midd	lle, Maiden	Surna	me)		
10	L	Ţ.	Villia	ım	W.		Dave	еу				Ida	1			Wh	eele	30	
		19a. Informant's				,				-	,			ral Route Nun				. ,	
	L		Brenn	lan	/ da	ught	er	Tan =								_		Md 2170	2
	2	20a. Method of I	2 Crema			oval from	State		lace of Disperentery, cre					Date				r Town, State	
	L	4 Donatio					1	Hol	y Red					9/2008				Maryla	nd
ouce	1	21. Signature o	I Funeral Se	ervice L		ole	200	M	/					auffer ke/Fre			Hon MD	ne 21702	
	t	23a. Part 1. Ent	er the disea	ase, or	complicati	ions that	caused th	he death										Approxima	te
an		Immediate dau	heart failure se (Final	e. List o	only one c	ause on	$\sim$		ntia									Interval Be Onset and	Death
al		disease or conc resulting in dea			a	Due to			uence of):									110/416	٥
er	١.	Coguentially liet	oon ditions		b														
ine.	li	Sequentially list of any, leading to cause. Enter Un Cause (Disease that initiated eve	immediate nderlying	Į		Due to	(or as a	consequ	uence of):										
Examiner		Cause (Disease that initiated eve resulting in deat	or injury ents th) Last	1	c	D t-	/												
cal E	ľ	ioodiang an dod	in Laoi			Due to	(or as a	consequ	uence of):										
				67	d														
Physician/Med		IF FEMALE: 23b. Was deced	lant progna	nt	23c.		utcome of									23d. D	ate of de	eliverv	
icial	'		12 months			4 ☐ Preg	birth 2 gnant at ti			□ Ectopic p □ Other <i>(st</i>		1			.		lonth		Year
hys	L	9 ☐ Unkno			<u> </u>	9 Unk	nown												
by P		Part II. Other sig	gnificant co	onditio	ns contrib	outing to d	death but	not resu	ulting in the u	inderlying c	ause give	n in Part	l.	23e. Did	d tobacco	ise coi	ntribute	to the cause of	death?
ed	-													1	Yes 2	□No	3 🗆 F	Probably 4	Unknown
Completed														24a. Wa	as an topsy	24b	. Were a	utopsy findings completion of o	available ause of
5														pei 1 □ Yes	rformed?		death?		
Be (		25. Was case re examiner?	eferred to m	edical	11	sito!:					Je.			th (Check onl)	y one)				
၉	L	1 ☐ Yes 2	No		Hosp	1			ER/Outpatie			4 PUN	ursing Ho	ome 5 Re				ecify)	
ion	12	27. Manner of D 1 Natural	5 🗆 F	ending		∠8a. Date (Moi	e of Injury nth, Day,	Ye <i>ar)</i>	28b. Time of Injury	of 2	28c. Injury Work	?	INC	28d. Describ	e how injur	у осси	rred		
icat		2 ☐ Acciden 3 ☐ Suicide	6 □ 0	nvestiga Could n	ot be	28e Plan	e of Inium	v - At ho	me, farm, st			/es 2□	11/10	28f Location	(Stract c-	od Nive	horor	Rural Route Nur	nher.
Certification:		4 Homicio	le C	determi	ned	build	ding, etc.	(Specif)	()	out, lactor)	, onlo				own, State		ו ווח ופתו	iorai rioute NUN	1001,
	1	29a. Certifier (Check only	21 Me	dical	vaminer	· On the	hasis of e	ayamina	tion and/or i	rvestigation	in my o	ninion de	ath occur	, and due to the	e date and	1 nlace	and du	ie to the cause/	5)
Medical	1	one) 29b. Signature a	and title of o	ertifier	1-1/	and mar	nner state	ed.		296	. License	number			29d Da	te sian	ed (Mor	nth, Dav. Year)	
	1	) Oignature			Tre	1-0	7			L	00%	222	-3		12	-/13	7/0.	9	
	3	30. Name and a	ddress of p	erson y	vho comp	leted cau	use of dea	ath (Item	23a) (Type,	Print) 0	PIVE	e, F	212e	ELIC	K, M	P	-2	ith, Day, Year)	
State	3	31. Date filed (A	Month, Day,	Year)	. 0007	32.	<b>F</b> egistrar'	's Signat	ture	l M	,								
gistrar			建し	1 9	ZUU	5	English S.	0 1	U. P.										
1/2001						V													

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State		State of	Marylan		artment of I			lental Hy	giene			
	_		Registrar  1. Decedent's Name (F	First, Middle, Las	et)		Ce	rtificate of	Deam		2. Date of Dea	Reg. No.	2008	3 3	13098
Н	Physici		Raymond	Perr	,	illets					Month 12	Day	Year 08	0.	0800 M
and the same	/Medio Examin		4a. Facility Name (If no				<u>.</u>	4b. City, Town, o			4c. County of Death				
and de				(egjoNAL	MIDICAL				54/15/	4/1/ 24 Hrs.			Nicon.		
	Funeral Director		5. Social Security Numb 526–60–5235	5 1	ex / KDM 2□F	67 Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	Hours	Min.	8. Date of Birt (Month Da 04/15/	1941		rthplace cuntry)	(State or Foreign
	land wo		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location							10d. Inside C			nside City Limits		
	Mary a-f she	tor	Maryland	Wicomic	:0	Ede	en							1	□Yes 2 No
	or 28;	Directo	10e. Street and Numbe	er		10f. Zip Code 10g. Citizen of What						zen of What C	ountry?		
	ath wi		14620 Wo	oodland				2182					USA		
36	'natural", or items 23a or 28a-f show ideal Evar. I net rust be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 3 ☐ Widowed 4 ☐		Armed Ford	12. Was Decedent Ever in U.S. Armed Forces? <ul> <li>1 □Yes 2 No</li> <li>If Yes, Give</li> </ul>		J.S. 13. Was Decedent of Hispanic Origin? (\$ If Yes, specify Cuban, Mexican, Puer  1  Yes 2XNo Specify:			eify Yes or No- Rican, etc.)	Black, Whi	P. Race - American Indian, Black, White, etc.  Specify: white		
9-0	2 hour		15.	. Decedent's Ed	ucation		16a. Dece	dent's Usual Occup	pation			16b. Kir	nd of Business		
215		Completed	(Specify of Elementary/Seconda	only highest gra ry (0-12)	de completed) College (1-4	lor 5+)		kind of work done DO NOT use retire	during mos ed)	st of workin	ng				
21	e filed within al Hygiene. I other than '	Con	12	-4 A 61-4-41 - 14)	2		publ:	ishing	40.14-11	- I- N	(Fin ) A ( ) ( ) ( )		one bo	ok	
anc	ld be fil lental H ked otl ic ever	Be (	17. Father's Name (First Franklin S		Willets						<i>(First, Middle,</i> Baker	Maiden S	Surname)		
Maryland 21215-0036	shou and N is mar	오	19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State,									Zip Cod	e)		
ore,	and 2 Health Im 27 her tra		DeAnn Will		.e	lon r		520 Woodl							
	Pages 1 nent of H ant: If ite ary or ot		20a. Method of Disposi 1 ☑ Burial 2 ☐ C	remation 3 🗆		ale		sition (Name of matory or other pla			ate		cation - City or		
ij	permit. Page Department Important: If any injury o		4 ☐ Donation 5 ☐ 21. Signature of Funer			To		Cemeter		1/2/0			George		
Ba	Dep lmp		VUK	bell	im	CFSI	0	501 Snow	Fune Hill	Rd.	dome Pr , Salis	oies bury	, MD 2	Ass 1804	ociation
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and Death										rval Between		
	Physician /Medical		disease or condition a.												
	Examiner		Due to (or as a consequence of :												
		ner	Sequentially list condition if any, leading to immediate. Enter Underlying	ions, diate	b. Due to (or as a consequence of):										
	ecute and transi	Examiner	Cause (Disease or injuthat initiated events resulting in death) Last	c Due to (or as a consequence of):											
68760,	eath certificate be executed attending physician and for use as the burial-transit	al E	rooding in doday case		d										
687	ifficate g phys	edical			.d				· · · · · · · · · · · · · · · · · · ·						
Box	th cert tendin r use a	an/M	IF FEMALE: 23b. Was decedent pre	eynanı T	23c. If yes, outco	ome of pregna		☐ Ectopic pregnand	ev.			2	3d. Date of de	elivery	į,
.O.	w requires that the dea s been signed by the at should be detached fo	Physician/M	in the past 12 months?  1   Yes 2   No 9   Unknown							-		Month	lonth Day Year		
S, G.	es thai igned l	by P	Part II. Other significan	1 /	1 1/		ulting in the u	nderlying cause giv	ven in Part I			23e. Did tobacco use contribute to the cause of deal			
ord	requir	ted	N_N	10/1	hnflan	in					1 🗆 Y	es 2	√No 3□ P	robably	4 🗌 Unknown
Division of Vital Records,	e has t ge 2 s	Completed								_	24a. Was a autop: perfor	sy			ndings available ion of cause of
tal	ician: The certificate ector, pag	ø.	25. Was case referred	to medical					26 Diace	of Death		2 No		s 2 🗆 I	No
<u></u>	Physicia this cer al direct	TOB	examiner? 107 Yes 2 ☐ No	r	Hospital: 1 ☐ In	oatient 2 🗆	ER/Outpatier	nt 30 DOA Oth	or:		ne 5 ☐ Resid		☐Other (Spe	ecify)	
0	ding Pt J. After th funeral	ü	27. Manner of Death	Pending	28a. Date of (Month)	Injury Day, Year)	28b. Time of Injury	Wor			8d. Describe h				
sio	ttendi death. stor: A	icati	2 Accident	Investigation  ☐ Could not be	-	f Injune At he	ma form atr		Yes 2	-	Of Location (C				
<u> </u>	al or A s after il Direction	Certification:	4 ☐ Homicide	determined	building	, etc. (Specif	y)	eet, factory, office		2	8f. Location (S City or Tow	treet and n, State)	l Number or H	ural Hou	te Number,
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: Attentis certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical (	29a. Certifier (Check only one)	Certifying Phy Medical Exam	ysician: To the bas iner: On the bas and manne	sis of examina	wledge, deatl tion and/or in	n occurred at the ti vestigation, in my	ime, date a opinion, dea	nd place, a ath occurre	and due to the ded at the time, d	cause(s) date and	and manner a place, and du	s stated.	cause(s)
	To the within To the Comp	Me	29b. Signature and title	of certifier	0	()_	-0	29c. Licens			2	29d. Date	signed (Mon	th, Day,	Year)
	<b>.</b>		Kruth	n a	Dan	res 1	M	P55	142	7		)te	imbr	29	2008
	1080		30. Name and address	0 1	0	of death (Iten	23a) (Type,	Print)	C.	1, 1	2 73	1.1	. ~	1	, 2008 21804
	Sta	te	31. Date filed (Month, D			gistrar's Signa	ture	JId 27.	Just	E 6	05 36	uso	Ury , 110	Q.	00/
	Registr		DE	C 2 9 20	08	eur ,	G A	will							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND TITEM#30 PEDVR G887 of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 22, 2008 December 1950 Manuel Glen Ward /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Harford Memorial Hospital Harford Havre de Grace f Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, Apr. 19, 1 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) **Funeral** Days Hours 10X M 2 □ F 46 218-72-1723 1962 Pennsylvania Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State r 28a-f show notified at 1 XYes 2 No Director Harford Aberdeen MD 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number "natural", or items 23a or edical Examiner must be r 21001 U.S.A. 99 Woodland Green Way Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 3€ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√☐ No Specify: Specify: White Be Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 7 Is marked other than "natur traumatic event, the Medical 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Disabled Disabled 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Susie Ellen Woods John Ward မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s
Department of Health ar
Important; if Item 27 Is
any injury or other trau 99 Woodland Green Way Aberdeen, MD 21001 Valarie D. Ward (Spouse) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Baker Cemetery 12/27/08 Aberdeen, Maryland 22. Name and Address of Facility
Tarring-Cargo Funeral Home, P.A.
Marvland 21001-3399 21. Signature of Funeral Service Libensee 23a. Part1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 24 hoves **Physician** /Medical Due to (or as a consequence of): Prisumer LA Examiner 72 hours Sequentially list conditions, it cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Division or Vital Records, P.O. Box 68760, Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by MINIS 2 No 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes \_\_\_\_\_\_No 24a. Was an autopsy performed?

1 Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To npatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and ma 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 056296 12-23-2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 602 South Atwood RD Suite 206 Bel Air, MD 21014 32. Registrar's Signature 31. Date filed (Month, Day, Year). Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav **Physician** Month Year Hugh W. 7:05 ам Yarrington December 23, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Montgomery General Hospital 01ney Montgomery 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Days Hours 1**x** M 2 □ F Months Min Yrs Director 143-03-5022 88 March 16, 1920 Massachusetts Usual Residence of Decedent 10a. State 10b. County 28a-f show 10c. City, Town or Location 10d. Inside City Limits any injury or other traumatic event, the Muchael Event and trust be notified at Director 1 ☐ Yes 2 ▼ No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 2900 N. Leisure World Blvd., #412 20906 USA Funeral items 12. Was Decedent Ever in U.S. Armed Forces? 1次□¥es 2 □ No If Yes, Give Year or Dates: WWTT 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 No Specify: ≥ Specify: 3℃Widowed 4 Divorced White "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than, Elementary/Secondary (0-12) College (1-4or 5+) Director, Customer Services Retail permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygis Important: If item 27 is marked other? 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Stephen Marchbank Yarrington Flora Edith Blackstone ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hugh J. Yarrington/Son 408 Rivers Edge, Williamsburg, VA 23185 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Data 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Dec. Parklawn Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 2008 Rockville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): Physician: The law requires that the death certificate be executed sician and burial-trans resulting in death) Last Due to (or as a consequence of): Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) signed by the a P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate 1 □Yes 1 ☐ Yes 2 ☐ No director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death After 28b. Time of 28d. Describe how injury occurred or Attending 1 Natural 5 Pending death. 2 Accident investigation 1 ☐ Yes 2 ☐ No after death 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital within 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) D0065024 10+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 18/01 Prince Philip Dr. Olneymo 20832 31. Date filed (Month DE 32. Registrar's Signature State 6 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Sheikh Abdullatif Yusif Husam 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, 4c. County of Death Boldimove amovitos If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 05/14/1946 . Age (In yrs. last birthday) Social Security Number 6. Sex 9. Birthplace (State or Foreign Months Days Hours 1 **⅓**M 2 □ F 540-78-0772 62 Jordan Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1709 Mount Pisgah Ln. Apt#22 20903 Jordan 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: Arab 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Salesman Furniture 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Abdel Latif Sheikh Yusif Bahieh Sheikh Yusif 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20903 Mohammad Yusif / Son 1709 Mt. Pisgah Ln.Apt#22, Silver Spring, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 🔀 Removal from State 12/ 30/08 Ammam, Jordan Family Cemetery 4 Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Universal Mortuary Inc. Kennedy St NW, Washington, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Myocardia disease or condition resulting in death) Due to (of as a consequence of) Sequentially list conditions, in the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 □ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation

/Medical Examiner or Attending Physician: The law requires that the death certificate be executed burial-tran physician sthe burial as use Po signed by the a

P.O. Box 68760,

of Vital Records,

Division

Hospital

To the within 2

2

**Physician** 

Examiner

**Funeral** 

Director

28a-f show

items 23a

6

'natural",

is marked other than

Department of Healt Important: If item 2 any Injury or other once.

**Physician** 

filed withir Hygiene.

be f

Pages 1

timore, Maryland 2121

Director

Funeral

2

Completed

2

Examiner

Physician/Medical

Completed by

Be

Certification: To

Medical

other traumatic event, the Midical Examinar cust be notified at

/Medical

has page 2 s certificate within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

3 Suicide

4 Homicide

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated

6 ☐ Could not be

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5601 dward Seidel MID

State Registrar 31. Date filed (Month, Day, Year) 24 2008



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month Year **Physician** 1950 M December 21 2008 Hallie C. Adgerson /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner Prince Cheverla Prince 6 corges Hox If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Months Min. 1 💢 M 2 🗆 F Days Hours Director 251-20-0712 2/15/1924 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1. Yes 2 □ No Director DC Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 1801 Fort Davis Street, SE 20020 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No 7 / 1943 If Yes, Give 14. Race - American Indian, Black, White, etc 1 XiYes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify \$ Specify: Black 3 Widowed 4 Divorced 12/1945 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) th and Mental Hygiene.

27 is marked other than "
r traumatic event, In a Men Elementary/Secondary (0-12) College (1-4or 5+) Security/Police Federal Government 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hazie Adgerson Lester Griffin ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health Calvin Adgerson/Son 2905 Upland Ave., Forestville, MD 20747 Item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any injury or conce. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Washington National | 12/27/2008 | Suitland, MD 21. Sign vure f Funeral Ser 22. Name and Address of Facility Strickland Funeral Services 6500 Allentown Rd., Camp Springs, MD 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final Arteriose Physician -ero Tic disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence or). attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 Tyes 2 No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has t rector, page 2 s autopsy perform 1 ☐ Yes 2 1 No 2 □ No After this certification funeral director, p 25. Was case referred to medical examiner?
1 ☑ Yes 2 ☐ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ☐ ER/Outpatient 3 ☐ DOA 1 Inpatient Medical Certification: To 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 [TNatural 5 Pending investigation ours after death.
neral Director: Af
filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou

To the Fune

completely fil (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

4+1

SALVADO

31. Date filed "(Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year

3001

State of Maryland / Department of Health and Mental Hygiene 43103 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Agnes Adler 20, December 2008 10:51A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2 F Hours Months Days 577-54-2239 80 Director **1**928 Hungary Usual Residence of Decedent death with the Maryland 10a State 10c. City, Town or Location show 10d Inside City Limits r than "natural", or items 23a or 28a-f sho the Medical Examiner mast be notified at Director 1XYes 2 ☐ No Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 431 Christopher Ave #23 20879 United States of America Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian. of 2 should be filed within 72 hours after that and Mental Hygiene.
27 is marked other than "natural", or iter traumatic event, the Mexical Examinar 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 X No Specify: \$ Specify: Caucasian 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 Hair Stylist Cosmetology 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be ' Ferdinand Balla Elizabeth Gruen ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important; If item 27 is
any Injury or other trau Ivan Adler - Son 417 Christopher Ave #T2 Gaithersburg MD 20879 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Ft Lincoln Crematory 01/06/2009 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, Maryland 22. Name and Address of Facility Simple Tribute Funeral & Cremation 21. Signature of Eugeral Service Licensee Wilh 1040 Rockville Ave, Rockville MD 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cardiopulmonary arrest 20 minutes /Medical Due to (or as a consequence of): Examiner Gram negative sepsis 3 days Sequentially list conditions, Examiner Due to (or as a consequential of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Cholangitis 3 days and Due to (or as a consequence of): P.O. Box 68760 attending physician Common duct stone Physician/Medical 3 days as nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ίοι in the past 12 months? 1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 I Inknown signed by Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 Kidney stone disease 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 1 ☐ Yes 2 No 2 🔽 No the Hospital or Attending Physiclan: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To 1X Inpatient 2 ER/Outpatient 3 DOA this in by the funeral 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After . 1 ሺ Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death e Funeral Director: 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) December 20, 2008 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alan N. Schulman, MD 14955 Shady Grove Road Rockville Md 20850 31. Date filed (Month, Day, Year) State Registrar DEC 29 2008

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygienes 43104 1 - For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 12/25/2008 1838 James Donovan Bush /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 5102 Kenilworth Ave., Apt. Hyattsville Prince George's If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 X M 2 □ F Months Days Hours Min. 66 213-44-1450 **Director** 03/23/1942 Frostburg, MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertall Hygiene. Important: If them 27 is anatked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Nextern Evening representation and 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits 1 TYPYes 2 □ No Directo Maryland Prince George's Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20781 5102 Kenilworth Ave., Apt. 5 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 (X) Yes 2 □ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 🛣 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Black Specify: \$ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4or 5+) Driver Public Transportation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Eugene Bush Rena Van Buren 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charity M. Bush / Wife 5102 Kenilworth Ave., Apt. 5 Hyattsville, MD 20781 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veterans :1/8/2009 Cheltenham, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Jack A. Wilson, MO 1246 Cedar Hill FH 4111 PA Ave., Suitland, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Fatal Cardiac Arrythmia disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Physician/Medical phys the as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐Yes 2 ☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 □ Yes 2 🔀 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 \sum Nursing Home 1∐ Yes 2∭XNo 5 Residence 6 □ Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 😡 Natural 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 3 🗌 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 ED Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0067553 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 Cheverly, Maryland 3001 Hospital Drive Liu Yiju, M.D.

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

DEC 3 0 2008

P.O. Box 68760.

of Vital Records.

Division

32. Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) December 22, 2008 **Physician** 4:45 A M Douglas Baker /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 30 Fulton Avenue Walkersville Frederick | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Feb. 1 1, 19965 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 🔀 M 2 🗆 F MaryTand 43 Director 218-50-4613 Usual Residence of Decedent permit. Pages 1 and 2 st ould be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumortic event, the Nedles Event in the Legisland once. 10d. Inside City Limits 10a State 10h. County 10c. City, Town or Location Walkersville 1 ∏ Yes 2 □ No Maryland Frederick Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21793 30 Fulton Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 █XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No à If Yes. Give Specify: White 3 Widowed 4 Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction Business Owner/Operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Flohr Naomi Baker ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
30 Fulton Avenue, Walkersville, MD 21793 19a. Informant's Name/Relationship (Type. Print) Ellen Baker/Wife Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Stauffer Crematory 12/23/2008 Frederick, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stauter Tunera Home, P. 21. Signature of Funeral Service Licenses 1621 Opossumtown Pike, Frederick, MD 21702 23a. Par 1. Inter the disease, or complicates that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shick, or hear failure. List only one cause each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** seconds AS451016 /Medical Due to (or as a nsequence of): Examiner minutes rexa Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as consequence of): Examiner attending physician and for use as the burial-transit law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ) alivary Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No 2 No Division of Vital To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To nours after death.

neral Director; After this

filled in by the funeral di 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a

To the Funeral C

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State

Registrar

Yun 31. Date filed (Month, Day, Year) 12/12/08

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DFC 2 3 20

MD

DEC 2 3 2008 June 16 Spelle

D0067442

			For State Registrar		State o	f Marylar		artment of <i>rtificate of</i>	Health and I Death	Mental Hy	gien Reg. No	- 20	08	43	106
			1. Decedent's Name (First. Middle, Last)  2. Date of Death											3. Time of D	
	Physicia /Medic		Decry rachiteen parry									er 24, 2008 8:39 a			a™
	Examin		4a. Facility Name (If not	institution,	give street and nu	mber)			or Location of Death		4c. County of Death				
- 1			Suburban H				Bethes			Montgomery					
	Funeral Director		5. Social Security Number  208-16-3053  6. Sex 1 □ M 2 ☑ F  7. Age (In yrs. 82			If Under 1 Year Months Days		8. Date of Bi (Month, D Jan• 1	lrth Pay, Year L8	9. Bi		irthplace (State or Foreign Country) ennsylvania			
-	and ww		Usual Residence of Dece 10a, State 10b	edent c. County		10c. C	ity, Town or Lo	cation					10	Od. Inside City	Limits
Mary	f shc	to	Maryland Montgomery Rockville											1 □Yes 2	
	r 28a- notif	Director	10e. Street and Number		noncyome	Ly		10f. Zip Code	16		10g. Citizen of What Country?				
3	n wirr 23a o st be	a D	4605 Kem	per S	treet			20853				USA			
0000	permit. Fages I and 2 should be filed within 72 hours after death with frie maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I've "Modical Examiner must be notified at once.	by Funeral	11. Marital Status 1 Never Married 3 Widowed 4		Armed Fo	2 <b>√</b> No ve No		Was Decedent of f Yes, specify Cul I □Yes 2□No	Hispanic Origin? (Spoan, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)	0-	Black	- America , White, e		
	"natural	Completed I	15.	Decedent's		ates.	(Give	dent's Usual Occu kind of work done OO NOT use retire	during most of work	king	16b. h	Kind of Bus	siness/Ind	ustry	
7	than	дшс	Elementary/Secondary	y (0-12)	College (	1-4or 5+)		<u>ceptioni</u>	,		Arch	diagon	o of I	Washingto	~n
3	Hyg other ent, I	Be C	17. Father's Name (First,	t, Middle, La	a <i>st)</i>		ı ke	ceptioni	18. Mother's Nam	e (First, Middle				мазішідо	
ם ב	Aenta Aenta rked tic ev	To B	Chads Cha	lfant	Bradmon				Ruth F	lorence	Ne:	lan			
a ,	and Nama	Ξ.,	19a. Informant's Name/F	Relationshi	p (Type. Print)		1	-	t and Number or Ru			,		,	
	ealth n 27 i		Walter J.		, Sr./Hu	sband	46	05 Kempe	r Street,	Rockvi	lle	, MD	2085	3	
mit. Pages 1 a	rages in ment of Historiant: If iter ury or oth		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  Gate of Heaven Cemetery  20c. Location - City or Town, State  20c. Location - City or Town, State  20c. Location - City or Town, State  20c. Silver Spring, Mary 1a										vland		
ה המור	Depart Depart Import any inj		21. Signature of Funeral	I Service Li	. 1 / 1 10 10 1	rer	F 5	Name and Addr rancis J 00 Unive	ess of Facility • Collins rsity Blv	Funera d. W.,	1 H	ome I	nc.		
	hysician /Medical xaminer	g la	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Pneumonia  Due to (or as a consequence of):										Approximate Interval Betwe Onset and De 2 week	ath IS	
		ē	Sequentially list condition	ons,		b. Chronic Obstructive Pulmonary Disease								10 years	
7	ansit	Examin	Sequentially list condition any, leading to many cause. Enter Underlying Cause (Disease or injury)	9 <b>4</b>		(0)	(100000)								
into to concutad	physician and the burial-transit	I Exa	that initiated events resulting in death) Last		c Due to	Due to (or as a consequence of):									
	physi the t	edical			d										
Division: The law continue that the doath coult		Physician/Me	IF FEMALE: 23b. Was decedent preg in the past 12 mont 1 ☐ Yes 2 🛣 No 9 ☐ Unknown	су			23d. Date Mon		ry Day Yea	ar					
1	ned by deta		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use con								use contri	contribute to the cause of death?			
	an sign	ed by								1 🗆	Yes 2	2 □ No :	3 <b>⊠</b> Proba	ably 4 🗆 Uni	known
The low ro	cate has been s	Completed									psy ormed?	pr de	ere autoprior to comeath?	sy findings avanpletion of cau	ailable se of
1	nis certificate director, pag	Be	25. Was case referred to medical examiner?  26. Place of Death (Check only one)												
Dhire	rthis o	၉	1 ☐ Yes 2 1 No			Inpatient 2		1 3 DOA	her: 4 \(\sum \) Nursing Ho	ome 5 ☐ Res	idence	6 □Othe	r (Specify	)	
Attending	The fife	ation:	27. Manner of Death  11X Natural 5 Pending 2 Accident investigation  28a. Date of Injury (Month, Day, Year)  28b. Time of Injury 28b. Time of Injury 4 Work?  1 Pending 1 Natural 5 Pendin												
	s after de	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rule City or Town, State)								r or Rural	Route Numbe	er,		
the Hoenitel or	within 2 Hours and Archard Within 2 Hours all Director; A completely filled in by the fr	Medical C	29a. Certifier (Check only one) 2 □	time, date and place opinion, death occur	date and place, and due to the cause(s) and manner as on, death occurred at the time, date and place, and due			nner as st	ated. the cause(s)						
Ę	O With	Σ	29b. Signature and title	certifier V	1 -	D		29c. Licen	se number D24571			ate signed		Day, Year) 2008	
	•		30. Name and address o						sington,	MD 2089	95				
	Sta Registra		31. Date filed (Month, Da	ay, Year) <b>29</b> 2	2008	degistrar's Signa	ature	de.							

Betty Barry 12/24/08 0839 AM

		For State Registrar		State of	f Marylar			of Healtl of Deat		lental Hyg		2008	43107	
Physicia /Medic		1. Decedent's Name (First, Middle, Last)  Aleida S. Barge						2. Date of I Month Decer			mber 23, 2008 6:12 p M			
Examin		4a. Facility Name (If not		e street and nur	nber)		4b. City, To	own, or Location	on of Death			ounty of Death  Montgome	rv	
Funeral Director		5. Social Security Numb 578-96-6230	per 6. S	ex □M 2 <b>X</b> SF	7. Age (In yrs. <b>86</b>	last birthday) Yrs.	If Under 1		der 24 Hrs. rs Min.	8. Date of Birth (Month, Day June 27,	)	9. Birthi Couba	place (State or Foreign	
Maryland -f show	tor	Usual Residence of Dec 10a. State 10 Maryland	b. County	omery	10c. Ci	ity, Town or Lo	cation					0d. Inside City Limits 1 ☐ Yes 2 🏝 No		
h with the 23a or 28a	al Director	10e. Street and Number			10f. Zip C			1	0g. Citize	n of What Cou	ntry?			
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Evention is used to retified at once.	by Funeral	11. Marital Status 1 ☐ Never Married 3 ☑ Widowed 4 ☐		12. Was Dece Armed For 1  Yes If Yes, Giv Year or Da	2 <b>X</b> No ⁄e		Was Deceder If Yes, specify	y Cuban, Mexi	can, Puerto	ecify Yes or No- Rican, etc.)		Race - Americ Black, White, Decify:		
Maryland 21215-0036 nd 2 should be filed within 72 hours aft and Mental Hygiene. 27 is marked other than "natural", or rtraumatic event, the Wederal Event	Completed	15. (Specify of Elementary/Secondar 12	Decedent's Ed only highest gra ry (0-12)	ucation de completed) College (1	-4or 5+)	(Give life.	dent's Usual ( kind of work DO NOT use emaker	done during m	nost of workii	ng		of Business/In Wan Home	dustry	
aryland should be filed and Mental Hy, and Mental Hy, and marked othe umatic event,	To Be C	17. Father's Name (Firs						18. Mc		(First, Middle, I ia Arias	Maiden Su	irname)		
e, Mar l and 2 sho Health and em 27 is m ther traum	13	19a. Informant's Name Dolores Nava:	16805	MacDuff	f Avenue,	, Olney	MD 2083	2						
Baltimore, Dermit. Pages 1 a Department of Hee mportant; if item any Injury or othe	1	20a. Method of Disposit  10	Place of Dispo cemetery, crer clawn Men	matory or other morial F	er place) Park	Dec	26,	Rocky	tion - City or To					
Da Depa Impo any I			adt,	Jales	aused the deal		500 Univ	ersity I	Blvd. W	eral Home , Silver :	Spring	, MD 209	D1 Approximate	
Physician /Medical		shock, or heart fa Immediate Cause (Fina disease or condition resulting in death)	ilure. List only	one cause on ea	catic Bre	east Can		or dying, such	as cardiac c	respiratory arr	esi,		Interval Between Onset and Death 10 years	
Examiner po iis	Examiner	Sequentially list condition if any, leading to immediately cause. Enter Unionym Cause (Disease or injur	ons, diate	b. Dement Due to (	cia or as a consec	quence of):						4 ye		
8760, icate be executed physician and the burial-transit	dical Exan	that initiated events resulting in death) Last	ĺ	c	or as a consec	quence of);								
the death certification by the attending syched for use as	Physician/Med	IF FEMALE: 23b. Was decedent pre in the past 12 mor 1 ☐ Yes 2 ☑No 9 ☐ Unknown	nths?		Ectopic pred Other (spec			d. Date of delive Month	ery Day Year					
cords, F w requires that s been signed t should be deta	ò	Part II. Other significan	sulting in the u	nderlying cau	se given in Pa	rt I.		ne cause of death?						
Vital Reco	Completed									24a. Was an autopsy findings prior to completion of cideath?  1 □ Yes 2 ♣ No 1 □ Yes 2 □ No			mpletion of cause of	
of Vita Physiclan: r this certific	To Be	25. Was case referred t examiner? 1 ☐ Yes 2 No 27. Manner of Death		Hospital: 1 🔲 I	npatient 2	ER/Outpatier		Other: 4 🗆	Nursing Hor	n (Check only one) me 5□ Residence 6☑Other (Specify) Group ho				
Division of Vital Records, lor Attending Physician: The law requires the after death.  Director: After this certificate has been signed in by the funeral director, page 2 should be death.	Certification: To	27. Manner of Death  1 ★ Natural 2 □ Accident 3 □ Suicide 4 □ Homicide  28a. Date of Injury (Month, Day, Year)  28b. Time of Injury M   28c. Nigrey 28b. Time of Injury at Work? Mork? 1 □ Yes  28c. Place of Injury - At home, farm, street, factory, office							□No	28d. Describe how injury occurred  28f. Location (Street and Number or Rural Route Number,  City or Town, State)				
Hospita 4 hours Funeral tely filled	edical Co	29a. Certifier (Check only one)  15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										tated. the cause(s)		
To the within 2 To the complex	M	29b. Signature and title of certifier 29c. License number DC10200									29d. Date signed (Month, Day, Year)  December 26, 2008			
			is Prieba	t, MD	110 Irvi	ng Stree		Washingt	con, DC	20010				
Stat Registra	ır	31. Date filed (Month, D		23	egistrar's Signa	ature	de la							

1- For State	Or Waryland / Boparan	ent of Health and Mental Hy									
	Certific	ate of Death	Reg.	No. 2001	3 4310						
Registrar Physician/ 1. Decedent's Name (First, Middle,Lat	st)	12.5%	Date of Death     Month Date		3. Time of Death 1400 hrs						
Medical Examiner Deborah	Ann Bradley	Vi.	Month Da December 2	2, 2008	1400 1115						
4a. Facility Name (if not institution, given a 27549 Burrsville Road	ve street and number)	4b. City, Town, or Location of Death  Denton		Caroline							
	ex 7. Age (In yrs. last bi	,	. 8. Date of Birth(I	h(MM/DD/YYYY) 9. Birthplace (State or							
Talleral	M 2×F 44	Months Days Hours Min.	11-3-	1964 Foreign	ntryDelaware						
Usual Residence of Decedent											
10a. State 10b. County	10c. City, Town				10d. Inside City Limits  1 Yes 2 No						
pu fu by MD Caroli	ne	Denton	140-	Citizen of What Count							
MD Caroli  Toe. Street and Number  27549 Burrsvi  10e. Street and Number  27549 Burrsvi  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorce  15. Decedent's Education (Specify  16. Decedent's Education (Specify  17. Father's Name (First, Middle, Las  18. Francis  19a. Informant's Name/Relationship  Michael Bradle  Michael Bradle	lle Road	10f. Zip Code 21629	Tog.	U.S.A.	ry:						
the Country of the Co	12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? ( Sp	pecify Yes or No-	14. Race - Americ	an Indian, Black,						
11. Marital Status  1 Never Married 2 Marrie	d Armed Forces?	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	White, etc. White							
B L L S S Widowed 4 ★ Divorce	d If Yes, Give Year	1 Yes 2 X No specify:		Specify:							
Ag 15. Decedent's Education (Specify	, , ,	Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use reti	work done 1 ired)	16b. Kind of Business/Industry							
Elementary/Secondary (0-12)	College (1-4 or 5+)	Cook		Restaura	rant						
Flementary/Secondary (0-12)  1 2  1 3. Decedent's Education (Specify of Marin 12)  Flementary/Secondary (0-12)  1 2  1 7. Father's Name (First, Middle, Last	t)	18.Mother's Name	e (First, Middle, Ma	iden Surname)							
Francis  Francis	Bradley	_		urzynowsk							
19a. Informant's Name/Relationship		9b. Mailing Address (Street and Number or									
Michael Bradle		4155 County Rd. 56		ron, TX 77							
Michael Bradle  Wichael Bradle  Wichael Bradle  20a. Method of Disposition  1 Burial 2 Cremation 3  4 Donation 5 Other Special	Crem	atory or other place)		,							
► 6 0 E t	y: Summ	it Cremation Svc 1 22. Name and Address of Facility Pi	2-29-080	Camden-wy	oming, DE						
21. Signature of Funeral Service Lice	ensee	119 West Camden									
	np ications that caused the death. Do	not enter the mode of dying, such as cardiac			Approximate Interval						
/Medical failure. List only one cause on	failure. List only one cause on each line.  Death  Death										
or condition resulting in death)											
Sequentially list conditions,											
. cause. Enter Underlying Cause											
(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):										
a and and	d										
Ogdusadun Durial - Control Durial - Cont				23d. Date of delivery							
Division of Vital Records, P.O. Box 68760, within 24 hours after death.  Division of Vital Records, P.O. Box 68760, within 24 hours after death.  Division of Vital Records, P.O. Box 68760, and the function of the attending physicians that the death certificate has been signed by the attending physician of the function of the property of the propert	23c. If yes, outcome of pregnand  1 Live birth	2 Fetal death 3 Ectopic pregr	ancy		ay Year						
You again the man and the man	Pregnant at time of death	5 Other (Specify)		Ť							
Part II. Other significant condition	S CHINIOWIT	ting in the underlying cause given in Part I.	23e. Did tob	pacco use contribute to	the cause of death?						
Division of Vital Records, P.O. B as a feet death.  The law requires that the definition of Afternitis certification.  The law requires that the definition of the fine of the	o contributing to doday between		1 Yes	2 No 3 Prob	ably 4 🗸 Unknown						
Records, The law requires, froate has been sig, page 2 should be Completed			24a. Was ar		topsy findings available ompletion of cause of						
COrral law rate law r			autops perform	ned? death?							
25. Was case referred to medical		26.Place of Death (Check		100							
training 25 of the state of th	Hospital: 1 Inpatient 2 ER	VOutpatient 3 DOA Other Nurs	ing Home 5 F	Residence 6 🗸 Other	: Scene						
27. Manner of Death	28a. Date of Injury (Month, Day, Year)	b. Time of Injury 28c. Injury at Work?	28d. Describe ho	ow injury occurred							
The state of the s											
A Paragram	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Town, State)										
DIVISION  Division  Downs after death.  1	1 (-1	*	1	. (-)	nd.						
Division of Death  1	sician: To the best of my knowledge, ner:On the basis of examination and/	death occurred at the time, date and place, ar or investigation, in my opinion, death occurred	nd due to the cause I at the time, date a	e(s) and manner as statend place, and due to the	e cause(s)						
Certifying Physical Control one)  1 Certifying Physical Control one)  2 Medical Examination one)  29b. Medical Examination one)	and manner stated.	29c. License number		29d. Date signed (Mo							
	? 0	O.C.M.E.		December 23, 20	008						
30. Name and address of person w	no completed cause of death (Item 23	a)									
	· · · · · · · · · · · · · · · · · · ·	111 Penn Street, Baltimore, MD 21	201								
Laron Locke MD. Ass	istant Medical Examiner	The Fill Street, Baldinore, MB 21									

RHMH 17 Rev 1/2001 CME 2006

State of Maryland / Department of Health and Mental Hygiene Reg. No 2 U U 8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 12/27/2008 MADELYN EAST BUNTING 4:55 a /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Pocomoke City Hartley Hall Nursing Home Worcester If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Hours 1 □ M 2**X** F 10/09/1906 102 Virginia Director 213<u>-22-8847</u> Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he mother once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 XYes 2 No Funeral Director MD Worcester Pocomoke City 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21851 USA 101 Linden Avenue Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian. 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Baltimore, Maryland 21215-0036 Specify: Specify: white Completed by 3 XWidowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Retail Furniture Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Peter T. East Jennie Shrieves 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 101 Linden Ave., Pocomoke City, MD 21851 Dr. George S. Bunting, Jr. (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Salem Methodist Cemetery 12/30/2008 Pocomoke City, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Holloway Funeral Home, Professional Association 103 Linden Ave., Pocomoke City, MD 21851 1 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** oronar disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 246 to (or as a nonsequence of) Examiner requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Box 68760. Physician/Medical as attending properties for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a P.O. 9 I Inknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, icate has been sig , page 2 should b 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed certificate Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 Yes 2 No 27. Manner of Leath Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred ne Hospital or Attending Pl n 24 hours after death. ne Funeral Director: After the Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Z-Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 24 and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 12-27-2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BA La. 31. Date filed (Month, Day, 32. Registrar's Signature Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Year Physician 2045 M 20, 21,2008 neodore /Medical Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Wicomico Dalispi Peninsula Regional Medical Ctr. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Year) Months Days Hours Min. 218-48 Usual Residence of 6 Director maryland of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10a. State 10b. County ÛYes 2□No **Funeral Director** 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number ABT lo Tell 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify: þ 3 ☐ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) armwork 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pa 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 4 □ Donation 2 ☐ Cremation 3 Removal from State 5 Other (Specify) 1. Signature of Funer | Service Name and Ad ress of Facility PER 00 complications that caused the death. Do not enter the mode only one cause in each line. 25a. Part1. Enter the diseas shock, or head failure. of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) tho have /Medical Due to (er as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 70> a signed by the attending physician and do be detached for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Probably 4 Unknown certificate has been si rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 1∐ Yes 2 1 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ 1√10 2 ☐ ER/Outpatient 3 ☐ DOA မ 1 Inpatient within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation Injury 1 🗌 Yes 2 🗌 No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BA 3 Robins, M.D.
32. Ragistrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

William 31. Date filed (Month, Day, Year)

DEC 2 9 2008

200 C

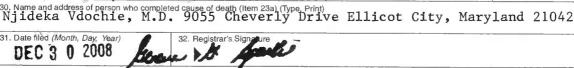
IVIC

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death John Corby **Physician** December 2008 6:40 A. M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Heartland Healthcare Center Adelphi Prince George's | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | April 25,1920 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**X** M 2 □ F Director 528-32-9719 Massachusetts Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits show r 28a-f sh notified D.C. Director Washington 1XXYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? d other than "natural", or items 23a or event, the Wadical Evaminer must be a 1440 N Street, N.W. 20005 U.S.A. Funeral death v 12. Was Decedent Ever in U.S. Armed Forces? 1XXes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after Never Married 2 ☐ Married Maryland 21215-0036 1 □Yes 2XXNo Specify Specify: White þ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Health and Mental Hygiene. em 27 Is marked other than ther traumatic event, the Elementary/Secondary (0-12) College (1-4or 5+) U.S. Coast Guard Auditor 18. Mother's Name (First, Middle, Maiden Surname) Marianna Delli Priscoli 17. Father's Name (First, Middle, Last) Be Ferdinando Corbisiero ပ 19a. Informant's Name/Relationship (Type Print), Estate 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Matthew F. Shannon (Representative) 1420 N Street, N.W. Washington, D.C. 20005 permit. Pages 1 and Department of Health Important: If item 27 any injury or other troone. altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington Nat. Cem.Jan.6,2009 Arlington, Va. 22. Name and Address of Facility Marshall's Funeral Home, Inc. 21. Signatury 4217 9th Street, N.W. Washington, D.C. 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Prerenal Azotemia **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Undersing Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): sician and burial-transit requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) detached 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. ≥ Dementia 1 ☐ Yes 2XXX No 3 Probably 4 Unknown page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? The certificate 1 □ Yes 1 ☐ Yes 2 ☑ No 2½ No Physician: director, 25. Was case referred to medica Be 26. Place of Death (Check only one) Hospital: Other: 4 🙀 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 1∐Yes 2<sup>™</sup> No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation or Attending 1 □ Natural 2 □ Accident within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier юmpletely (Check only

State Registrar 31. Date filed (Month, Day, Year) DEC 3 0 2008

29b. Signature and title of certifier



29c. License number

D0051897

29d. Date signed (Month, Day, Year)

December 26, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygie 2e 1 8 Certificate of Death Reg. No. 1 - State Registrar 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Myrtle Inez Christian (U:45 PM 105 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Hospital Center Cheverly Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Dec. 22, 1915 Arlington, Va. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 1 ☐ M 2X F 93 578-24-7420 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits worle 10a. State 10b. County a 23a or 28a-f ehov 1XYes 2 No Director Bowie Maryland Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20721 U.S.A. 9927 Oxbridge Way Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 2 should be filled within 72 hours after and Mental Hygiene.

Is marked other then "natural", or Ite 1 Yes XXNo
If Yes, Give
Year or Dates: 1 Never Married 2 Married Black Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: Specify: 7 le marked other then "natural", o traumatic event, the Msdlcst Exa by ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Federal Government Elementary/Secondary (0-12) College (1-4or 5+) Administrative Assistant 12th grade 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Viola B. Hennings Eugene H.S. Plummer 19a. Informant's Name/Relationship (Type, Print)

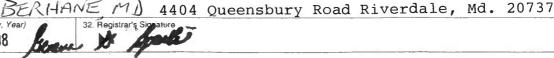
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code).

Robin Bunting (Grand-daughter) 9927 Oxbridge Way Bowie, Maryland 20721 item 27 l 01/02/2009 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of Hi Important; if iter any injury or oth XIXBurial 2 ☐ Cremation 3 ☐ Removal from State Maryland Nat.Park Jan.3,2009 Laurel, Md. 4 Donation 5 Other (Specify) 22. Name and Address of Facility Marshall's Funeral Ilome, Inc. 21. Sign sture of Fundral Service Licenses 4217 9th Street, N.W. Washington, DC20011 Park. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, under failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** DNEUMON:A disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leaving to infinediate cause. Enter Underlying Cause (Disease or injury Due to (or as a nonsequence of Examine requires that the death certificate be executed attending physicien and for use as the burial-transit EAILCILL" CONGESTUG MEANT that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2K 110 Division of Vital : After this certific tuneral director, 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? al or Attending F s efter death. I Director: After id in by the funera Certification; 1 Natural 5 Pending investigation М 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours eft To the Funeral Di completely filled in 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) A00 83 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

cr 2

7510N BE 31. Date filed (Month, Day, Year) DEC 3 0 2008



State

Registrar

		-	1 - State of Maryland / Dep	artment of Health and I rtificate of Death	Mental Hygien Reg. N	2008 43113
	Physicia	an	1. Decedent's Name (First, Middle, Last)  Allen	arter		23 2608 10155 A M
100	/Medic Examin		4a. Facility Name (If not institution, give street and number)  The Johns Hopkins Hospital	4b. City, Town, or Location of Death  Baltimore City	4	c. County of Death
	Funeral Director		5. Social Security Number 231-30-6418 6. Sex 1 X M 2 F 80 Yrs.		8. Date of Birth (Month, Day, Year, MARCH 25,	
	Maryland	tor	Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or I           MD         PRINCE GEORGE S         LAUREL	ocation		10d. Inside City Limits 1 🔀 Yes 2 □ No
	with the la or 28a be notif	Director	10e. Street and Number 11423 LAURELWALK DRIVE	10f. Zip-Code		CA
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of health and Mental Hyglene. Important: If item 27 is marked other than "hatural", or Items 23a or 28a-f show amortant: If item 27 is marked other than "hatural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status  1 □ Never Married 2 ☑ Married  1 □ Never Married	Uses 2 Mo Specify:		SA  14. Race - American Indian, Black, White, etc.  Specify: BLACK
21215-0036	ithin 72 hour: ie. ian "natural" Medical Exa	Completed b	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)	edent's Usual Occupation e kind of work done during most of wor DO NOT use retired)	rking	Kind of Business/Industry
aryland 21	d be filed wi ental Hygien ced other th event, the	Be	12TH LABO 17. Father's Name (First, Middle, Last) BERKLEY HERNDON		P: me (First, Middle, Maid E CARTER	RIVATE en Surname)
Mary	12 should and Me	၉	19a. Informant's Name/Relationship (Type. Print)	ural Route Number, City	y or Town, State, Zip Code) MD 20708	
Baltimore, I	ages 1 and ent of Health t: If item 27 y or other tr			position (Name of ematory or other place)	Date 20c.	Location - City or Town, State SHINGTON, DC
Baltii	permit, P Departm Importar any injur		21. Signeture of Funeral Service Licensee  DONALD R. GRAY	22. Name and Address of Facility MA	RSHALL'S F	UNERAL HOME OF MD SUITLAND, MD 20746
	Physician /Medical		23a. Par 1. Enter the disease, or complications that caused the death. Do not e shock, or heart faillure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):		c or respiratory arrest,	Approximate Interval Between Onset and Death
8760,	cate be executed bhysician and burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter U. Joseph S. Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  c			
Box 6	The law requires that the death certifica te has been signed by the attending ph page 2 should be detached for use as the	Physician/Med		☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery  Month Day Year
rds, P.O.	w requires that the been signed by should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death?
Division of Vital Records,		Completed	-		24a. Was an autopsy performed 1  Yes 2	24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 2 No
f Vita	Attending Physician; The death. ector: After this certificate by the funeral director, pa	To Be	25. Was case referred to medical examiner?  1  Yes 2 No Hospital: 1 Inpatient 2 ER/Outpati	Other:	ath (Check only one)  lome 5 ☐ Residence	6 ☐ Other (Specify)
ion o	nding Phy: th. After this e funeral d		27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation 2 28a. Date of Injury (Month, Day Year) 28b. Time (Month, Day Year)		28d. Describe how in	jury occurred
Divis	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, s building, etc. (Specify)		City or Town, Sta	
	the Hospital or hin 24 hours afte the Funeral Dire	edical	29a. Certifier (check only one)  1.★ Certifying Physician: To the best of my knowledge, detection on the basis of examination and/or and manner stated.			
	To the within 2 To the comple	Me	29b. Signature and title of certifier	29c. License number .  RES - 000		Date signed (Month, Day, Year)  EUNSEK 23 2008
A	6		30. Name and address of person who completed cause of death (Item 23a) (Type SUSAN QUAN			St, Baltimore, MD, 21287
	Sta Regist		31. Date filed (Month, Day, Year)  32. Registrar's Signature	-		

			For State of Maryland  1 - State Registrar	I / Department of Healt Certificate of Dea	41-	2000 1.2111.									
			Decedent's Name (First, Middle, Last)	- Corumodio oi Dod	2. Date of Death	3. Time of Death									
	Physici /Medi		Evelyn Mildred	Cox	December	Day Year 9:12 a M									
· V	Examir	ner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Locati	ion of Death	4c. County of Death									
	Funeral		71 Simmons Lane 5. Social Security Number   6. Sex   7. Age (In yrs. la		nder 24 Hrs. 8. Date of Birth	Year) Cecil  9. Birthplace (State or Foreign Country)									
	Director		213-68-3884 1 DM 2 F 98	Yrs. Months Days Hou	Min. (Month, Day, Dec. 18,	1910 Couintry) Maryland									
	land ow II		Usual Residence of Decedent           10a. State         10b. County         10c. City,	Town or Location		10d. Inside City Limits									
	a-fsh	ctor	Maryland Cecil	Perryvi11	ا ۵	1 □Yes 2 No									
	with the Maryland a or 28a-f show by notified at	Director	10e. Street and Number	10f. Zip Code		g. Citizen of What Country?									
	er death w	Funeral	71 Simmons Lane	21903		U.S.A.									
9	after dea or items		11. Marital Status  1 □ Never Married 2 □ Married  1 □ Never Married 2 □ Married  1 □ Yes 2 ▼ No	13. Was Decedent of Hispanic If Yes, specify Cuban, Mex		14. Race - American Indian, Black, White, etc.									
003	hours after death with the Maryland tural", or items 23a or 28a-f show at Examinar must be notified at	d by	3 Widowed 4 □ Divorced If Yes, Give Year or Dates:	1 □ Yes 2√ No Spec	cify:	Specify: White									
15-	n 72 h n"nati	Completed	15. Decedent's Education (Specify only highest grade completed)	<ol> <li>Decedent's Usual Occupation (Give kind of work done during n life. DO NOT use retired)</li> </ol>	most of working	6b. Kind of Business/Industry									
212	d withi	mo	Elementary/Secondary (0-12) College (1-4or 5+)  Twe1ve Years	Homemaker		Personal Residence									
Maryland 21215-0036	be file ital Hy d othe event,	Be	17. Father's Name (First, Middle, Last)	18. Mo	other's Name (First, Middle, M										
ryla	hould of Men	မ	Kersey Frank Peters  19a. Informant's Name/Relationship (Type. Print)	121 M III A I I I I I I I I I I I I I I I I	Alice Pea										
	nd 2 s alth an 27 is i		Jane C. Thompson (Daughter)	19b. Mailing Address (Street and Number P.O. Box 159, Pen											
ore,	es 1 a of Hea fitem r othe			ce of Disposition (Name of netery, crematory or other place)		0c. Location - City or Town, State									
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, it is Medical Exagnoce.		4 Donation 5 Other (Specify)	ncipio Cemetery		erryville, Maryland									
Bal	permi Depa Impo any ir		21. Signiture of Funeral Service Licensee  22. Name and Address of Facility  Lee A. Patterson & Son Funeral Home  Perryville, Maryland 21993-0766												
				shock, or heart failure. List only one cause on each line.  Interval Between Onset and Death											
-	Physician /Medical		disease or condition resulting in death)  Due to (or as a consigned as a consigne	614 Mil.		Show and Boath									
7	Examiner			rice of).											
	ed sit	Examiner	Sequentially list conditions, if any leading to the cause. Enter Underlying Cause (Disease or injury that initiated events	rice off)		=									
	e be executed sician and burial-transit	Exan	that initiated events resulting in death) Last  C	nce of):											
68760,	ificate be executed g physician and as the burial-transit	ledical E	d												
		Med	IF FEMALE:												
Вох	The law requires that the death certifi ate has been signed by the attending l bage 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?  1	eath 3 Ectopic pregnancy		23d. Date of delivery  Month Day Year									
P.O.	at the de by the tached	hysi	1   Yes 22   No 9   Unknown 9   Unknown	Signature (appeary)											
Ś	res that signed I be det	by P	Part II. Other significant conditions contributing to death but not resulti	ng in the underlying cause given in Pa	art I. 23e. Did toba	acco use contribute to the cause of death?									
Records,	w requir been s should	Completed			1 Yes	2 No 3 Probably 4 Unknown									
Rec	: The law cate has page 2 s	mpl			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of death?									
ta	iician: Th certificate ector, pag	O	25. Was case referred to medical	26. Pla		ZNo 1 ☐ Yes 2 ZNo									
of Vital	Physician: this certific	To B		R/Outpatient 3 DOA Other: 4	Nursing Home 4 Residen	ce 6 ☐ Other (Specify)									
	ding h. After funer	tion:	✓ Natural 5 Pending (Month, Day, Year)	8b. Time of Injury at Work?  M 1 □ Yes 2	28d. Describe how	r injury occurred									
Division	il or Attending after death. Director: After d in by the funer	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At hom-		28f. Location (Stre	et and Number or Rural Route Number,									
٥	ital or rs afte al Dir led in	Cert	4 Homicide building, etc. (Specify)		City or Town,	State)									
	To the Hospital or Atten within 24 hours after deat To the Funeral Director: completely filled in by the	edical	29a. Certifier (Check only one)  29 Medical Examiner: On the basis of examination and manner stated.	edge, death occurred at the time, date n and/or investigation, in my opinion, o	e and place, and due to the cau death occurred at the time, dat	use(s) and manner as stated. e and place, and due to the cause(s)									
	To the within 2 To the comple	Mec	one) and manner stated.  29b. Signature and title of certifier	29c. License numbe	er 290	d. Date signed (Month, Day, Year)									
			Thouse Brends the	1) 1/2	2860	12/29/08									
	3		30. Name and address of person who completed cause of death (Item 2	3a) (Type, Print)	1.1. 111/1	Soll about									
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrary Signatur	3. Lulon A	THE HULL	1411/2/0/2									
	Registra		DEC 3 0 2008 A. A.	parket.		/									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 43115 State of Maryland / Department of Health and Mental Hygien 2 1 1 8 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Dec 30, 2008 8:45 pm <sup>™</sup> Louise Cammarata Marie /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 10 West Street LaVale Allegany If Under 1 Year
Months Days 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 □ F Hours Min. 198-38-0310 Oct 24, 1942 Director 66 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ir than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No MD Allegany LaVale Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 10 West Street 21502 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2 □ NK Specify þ 3 ☐ Widowed 4 ☐ Divorced white Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **Health Department** Nurse permit. Pages 1 and 2 should be filed Department of Health and Mental Hygir Important: If item 27 is marked other any injury or other traumatic event, it 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William McCloskey Louise Vensel 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10 West Street Robert Cammarata husband LaVale MD 21502 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ■ Muria! 2 □ Cremation 3 □ Removal from State Rocky Gap Veterans Cemetery 1/5/2009 MD Flintstone 4 ☐ Donation 5 Other (Specify) 21. Signature of Funeral Sen 22. Name and Address of Facility
Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease shock, or heart failure. Immediate Cause (Final disease condition MONIC OBSTRUCTIVE PULMUNMY DUGING **Physician** 5 years /Medical resulting in death) Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner sician and burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical the as IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months 4∐Pregnant at time of death 5 Other (specify) 2 NO the 9□Unknown 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Drobably 1 □ Yes 2 🗆 No 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 ILNO 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 ☐ Yes Other: 4 ☐ Nursing Home 5 ☐ Desidence 6 ☐ Other (Specify) 2 1 N 1 Inpatient 2 ER/Outpatient 3 DOA P To the Hospital or Attending Physwithin 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di this 27. Mann of Death 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Watural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined 29a, Certifier I 🗍 crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Ity (ICIAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 912 JETON PRIVE CUMBERLAND, MP 21502 CONTRIA JIZ

DHMH 17 Rev 1/2001

State Registrar

JOSE

Year)

31 Date filed Month Dev

32. Registrar's Signature

Fo the Funeral

Registrar

30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner Donna M. Vincenti, MD DEC 3 0 2008

and manner stated

- Imm

111 Penn Street, Baltimore, MD 21201

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

Year

No

29d. Date signed (Month, Day, Year)

December 23, 2008

Medical

State

29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 0450am December 31, 2008 DeBonis Nicholas /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death . County of Death Examiner Home tizens Gmce If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1 X M 2 □ F Yrs. Director 224-26-3671 83 <u> 11/02/1925</u> Virginia Usual Residence of Decedent filed within 72 hours after death with the Maryland r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 2 No Director MD Havre de Grace Harford 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ms 23a or 7 U.S.A. 730 Earlton Road 21078 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) r than "natural", or items the Medical Examiner ma 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Myes 2 No If Yes, Give Year or Dates: WW 1 1 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "r any Injury or other traumatic event, the Med one. Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James E. DeBonis Pearl Hash 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Hodges (Daughter) 1310 Montreal Drive, Aberdeen, MD 21001 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) Air Mem. Gardens: 01/05/2009 Bel Air. Maryland 22. Name and Address of Facility Zellman Funeral Home, P.A. ature of Funeral Service Licenses 123 S. Washington St., Havre de Grace, MD 21078 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last pue to (or as a consequence of) Examine that the death certificate be executed physician and sthe burial-trans Due to (or as a consequence of) Physician/Medical attending properties for use as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached for P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an page 2 s certificate has 1∐ Yes Division or Vital 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Be Hospital: Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 20 No 1 🔲 Inpatient 2 ☐ ER/Outpatient 3□ DOA Medical Certification: To this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred the Hospital or Attending 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No death. 2 Accident 6 Could not be determined 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours after
To the Funeral Dire
completely filled in b 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

bonis,

State Registrar

29b. Signature and title of certifier

ano 30. Name and address of person who completed cause

DHMH 17 Rev 1/2001

29d. Date signed (Month, Day, Year)

and manner stated

32. Regis

rar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 43118 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Ricky Lee Engle, I December 17, 2008 1:30 p. M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Kline Hospice House Frederick Mt. Airy If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) Months 1 ★ M 2 □ F 49 217-74-7957 December 21, 1958 Maryland Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d Inside City Limits Maryland Frederick Frederick ★ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 317 W. 7th Street 21701 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No 1 Yes 2 No White Specify: Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Roofer construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Irvin Engle, Sr. Etta Mae Coleman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dawn Engle - wife 317 W. 7th Street, Frederick, Maryland 21701 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State Stauffer Crematory 12-19-2008 Frederick, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Metaslasis Brawn disease or condition resulting in death) Due to (or as a consequence of): (Non small all Lung con us Due to (or as a consequence of) Due to (or es a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 DN 2 🗆 No 1 ☐ Yes

**Physician** /Medical Examiner

spital or Attending Physician: The law requires that the death certificate be execute nours after death.

real Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-trans.

Division of Vital Records, P.O. Box 68760,

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show be notified at

nust be n

6

er than "natural",

ulth and Mental Hygiene. 27 Is marked other than " r traumatic event, "

of Health a Item 27 Is other tra

F It permit. Page: Department of Important: If I any Injury or once. Director

Funeral

þ

Completed

Be

ပ

Examine

ò

Completed

Be

Certification: To

Medical

the Maryland

death 1

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 1 Inpatient 2 ER/Outpatient 3 DOA

28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

3 Suicide 6 ☐ Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State) The certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

6 ☐ Other (Specify)

29b. Signature and title of certifier

5 Pending investigation

1 ☐ Yes 2 ☐ No

27. Mann of Death 1 Watural

2 Accident

(Check only

29a. Certifier

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

46 8 Tho mas Dhyn Dr svire 29d. Date signed (Month, Day, 12/19/18

Frederich MD 21702

Marie J. Species

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

To the Hospital of within 24 hours at To the Funeral D

DEC 2 3 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 008 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 12 **Physician** 26<sup>pay</sup> 2008 Gertrude Edwards 5:20 рМ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5600 Wisconsin Ave Apt W106 Chevy Chase Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 2/8/15 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 578-18-9143 93 Hannover GY Director Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 28a-f show ?7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, Ite Mackel Eveningt in ust to notified at 1∏Yes 2∏No Director MD Chevy Chase Montgomery 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 5600 Wisconsin Ave 20815 USA Funeral 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 25 No If Yes, Give Year or Dates: Specify Specify: White þ 3 Vidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Je filed wit. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Yes Merchant Lingerie 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) it and 2 should be fill Health and Mental H tem 27 is marked oth ည Ernst Mueller Anna Rosenthal 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7315 Bannock Burn Ridge Ct. Bethesda MD 20817 permit. Pages 1 and : Department of Health Important: If Item 27 any Injury or other troonce. <u> Wolfgang Mueller - Brother</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) National Crematory 12/28/2008 Falls Church VA. 22. Name and Address of Facility Danzansky-Goldberg Memorial 21. Signature of June 1 Sovice Licens Chapels Pike Rockville MD 20852 1170 Rockville 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 5 days disease or condition resulting in death) Asperation Pneumonia /Medical Due to (or as a consequence of): Examiner Meningioma, Brain <u>4 years</u> Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 
 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☒ No Month Year Day 5 Other (specify) P.O. ed by the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 2 sign be icate has been siç , page 2 should b 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' certificate 1 ☐Yes 2 ☐ No 1 XYes 2 □ No : After this certification of the thick the th 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🖺 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Hospital or Attending 5 Pending investigation 1 🛭 Natural i 24 hours after death.

E Funeral Director: Af letely filled in by the fur 2 Accident 1 ☐ Yes 2 ☐ No Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor **To the Fune** completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D36797 12/28/2008

Registrar

DHMH 17 Rev 1/2001

State

10215 Fern Wood Rd. Bethesda MD 20817

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

Alan Sheff, MD

31. Date filed (Month, Day, Year)

DEC 29

State of Maryland / Department of Health and Mental Hygiene 43120 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2008 Mary Johanne Ford Dec 27 7:10 P M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 8372 Sunset Drive Ellicott City Howard If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 09-07-1940 7. Age (In vrs. last hirthday) Birthplace (State or Foreign
Country) 5. Social Security Number **Funeral** Months Days Hours 1 M 2 F Maryland 218 36 8046 68 Director Usual Residence of Decedent 10c City Town or Location 10a, State 10b. County 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at at 1 ☐ Yes Ž No Director Ellicott City MD Howard 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21043 United States 8372 Sunset Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14 Bace - American Indian. 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 □ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 1 and 2 should be filed wi Health and Mental Hygien om 27 is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Clarence W. King Sr. Mary J. Knickman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau William L. Ford, Jr./Husband 8372 Sunset Drive Ellicott City, MD 21043 Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Ardent Crematory 12-30-2008 Hanover, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. Den Ollins M01044 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) END-STAGE RENAL DISEASE Physician 2 MONTHS /Medical Due to (or as a consequence of): Examiner DIABETES MELLITUS YEXRS Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). certificate be executed イセストノ HYPERTENSION burial-trar Due to (or as a consequence of): Box 68760, physician COROHARY ARTERY DISEASE Physician/Medical イモイドし the attending IF FEMALE: nse s 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy Po Month Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f P.O. 9 Unknown signed by the sign of the sign Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ OF CHRONIC DISEASE, STROKE 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed CHRUNIC CHOLECYSTUTIS 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performe page death? 1 ☐ Yes 2 ☐ No certificate 1∐ Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5

Residence 6 □Other (Specify) 1 ☐ Yes 2 ☑ No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 2 After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: ospital or Attending hours after death. 5 Pending To the Hospins. within 24 hours after death.
To the Funeral Director: Aft 1 XNatural 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of 29d. Date signed (Month, Day, Year) D38296 Dec. 29, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FIEL LARKBROWN Rd, SHITE 201, ELKRIDGE, MG 21075 JOSEPH GIBBONS, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature parke Registrar

State of Maryland / Department of Health and Mental Hygiene 43121 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Gertrude FRADKIN 25,\_ **Physician** 2008 December 9:55 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery General Hospital 01ney Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Min. Mar. 28, 5. Social Security Number 9. Birthplace (State or Foreign Country)
New York 6. Sex 7. Age (In vrs. last birthday) **Funeral** Year 1 M 2 D F 96 1912 Director 088-09-7629 Usual Residence of Decedent 10a State 10c. City. Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1 □Yes 2X No Director Silver Spring Maryland | Montgomery 10e. Street and Number 10g. Citizen of What Country? ö 23a 15100 Interlachen Drive #314 20906 United States Funeral items ; 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 6 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates: white 2 Specify: 3 ₩ Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed within 7 I Hygiene. other than "n United Sprinkler Elementary/Secondary (0-12) College (1-4or 5+) 12 Bookkeeper Union Pages 1 and 2 should be filed vent of Health and Mental Hygient: If item 27 Is marked other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Samuel Hoffeld Fannie Nedlich ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 Is any injury or other trau 24 Pilar Court, Los Alamos, NM 87544 Dr. David Fradkin, Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 → Burial 2 Cremation 3 → Removal from State 4 Donation 5 Other (Specify)
Six thre 150 (rather) Montefiore Cemetery 12/30/08 Springfield Gdns., NY Torchinsky Hebrew Funeral Home 254 Carroll St., NW, Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Due to (or as a consequence of): 40 Minutes disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): law, requires that the death certificate be executed sician and burial-trans resulting in death) Last Due to (or as a consequence of) Box 68760, physician at the burial Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.0. ed by the a 9 Unknown cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Hypercholesterolem in 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an has autonsy Physician: The performed 2 No 1 □Yes After this certification funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred or Attending 5 ☐ Pending investigation 1 Natural death. 2 Accident 1 ☐Yes 2 ☐No within 24 hours after death To the Funeral Director; 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier completely (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M.D 12/25/2008 00058770 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Olner, Maryland Jeremy Graf, MD, 18101 Prince Philip Drive 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2008 For State Registra AMEND# Speciett, 12/29/08, PMN, MCO 43122 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death DEC 23, **Physician** 2008 Veronica Ramona Frankenberg 1644 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, JUN 27, Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🛣 F Director 1937 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, Ite Medical Execution at most and once. 10c, City, Town or Location 10a State 10b. County 10d. Inside City Limits Director 1 ☐ Yes 2 🛣 No Maryland Montgomery Montgomery Village 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? 19619 Brassie Place 20886 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📆 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status 1 ∏Yes 2 🕅 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🗓 No Specify ģ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sales Clerk Department Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be (UNAVAILABLE) Joseph Benda Myrtle ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19619 Brassie Place, Montgomery Village, MD 20886 Scott Frankenberg, Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/29/2008 | Glen Burnie, Maryland Atlantic Crematory 22. Name and Address of Facility
Thibadeau Mortuary Service, P.A. 21. Signature of Funeral Service Licensee Brine my The M01508 933 Gist Ave., LL, Silver Spring, MD 20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician SEPSIS** /Medical Due to (or as a consequence of): PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 XNo Month Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ **EMPYEMA** 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Ves 2 X No 1 ☐ Yes 2 X No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one)

Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trai Box 68760, physician the as attending use for Division of Vital Records, P.O. ed by the detached ate has been signed by page 2 should be detacl this certificate 24 hours after death.

Funeral Director: After this certificetely filled in by the funeral director, Certification: To

Baltimore, Maryland 21215-0036

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D62562

29d. Date signed (Month, Day, Year)

DECEMBER 24, 2008

State Registrar

completely

the within 2 To the I

ပ္

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 MEDICAL CENTER DRIVE, ROCKVILLE, MD 20850 MADHAVI HUBBLY, M.D.,

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

DEC 29 2008

Machan rubhy



		State of Maryland / Department	artment of Health and	Mental Hygi	ene	
	•	- State Registrar Ce	rtificate of Death	Reg	g. No. 2008	43123
Physicia		1. Decedent's Name (First, Middle, Last)	<del></del>	2. Date of Death Month	Day Year	3. Time of Death
/Medic	al .	Eulalia Geraldine Proctor Fenn		12-22-		04:45 M
Examin	91	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Deatl	1	4c. County of Death	oorgo
		Southern Maryland Hospital  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Clinton If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	Prince G	place (State or Foreign
Funeral Director	,	20-80-9806 1□M <b>3</b> N F 74 Yrs.	Months Days Hours Min.	(Month, Day,	Year) Cour	yland
p		Usual Residence of Decedent				
arylan show	ř	10a. State 10b. County 10c. City, Town or Lo			1	0d. Inside City Limits 1 ☑ Yes 2 ☐ No
vith the Maryla t or 28a-f shor	Director	Maryland Prince George Suitlar  10e. Street and Number	nd 10f. Zip Code	100	g. Citizen of What Cour	
with t			20746	100	USA	iti y i
er death w items 23a	Funeral	4909 Braymen Ave  11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No-	14. Race - Americ	
after or iter		1 Never Married 2 Married 1 ☐ Yes 2 X No	If Yes, specify Cuban, Mexican, Puert  1 ☐ Yes 2X No Specify:	o Rican, etc.)	Black, White,	etc. eri <sub>can</sub>
ours ral",	d by	3 XXWidowed 4 ☐ Divorced If Yes, Give Year or Dates:	The same opening.		India	n
filed within 72 hours after death with the Maryland Hygiene. Hygiene. than "natural", or items 23a or 28a-f show ent, it a Medical Evant with a most be invitined at	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of wor DO NOT use retired)		6b. Kind of Business/In	dustry
withir ene. than	Ę.	Elementary/Secondary (0-12) College (1-4or 5+)	Homemaker		Domest	ic
filed Hygi other ent, I	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Nar	ne (First, Middle, Ma	aiden Surname)	
2 should be filed within 72 hours and Mental Hygiene, is marked other than "natural", raumatic event, the Medical Ex-	일	William A. Proctor	Elizak	eth :	P. Procto	r
shou and h is ma		19a, Informant's Name/Relationship (Type. Print) 19b. Maili	ng Address (Street and Number or Re			
and			Woodville Rd,			
ges 1 t of H if iter		1 M Burial 2 Li Cremation 3 Li Removal from State	osition (Name of matory or other place)		Oc. Location - City or To	
t. Pag rtmen rtant: ijury		4□Donation 5□Other (Specify) Resurred		30/2008	Clinton, M	laryland
permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, If a Medical once.			<ol> <li>Name and Address of Facility</li> <li>Adams Funeral F</li> </ol>	Iome PA,	Aquasco M	ID 20608
		23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardia	c or respiratory arres	st,	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	y emboli			Onset and Death
, /Medical Examiner		resulting in death)  Due to (or as a consequence of):	0			
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying b.  Due to (or as a consequence of):				
uted d ansit		Cause (Disease or injury				
execu an and ial-trar	Exa	that initiated events resulting in death) Last C. Due to (or as a consequence of):				
cate be executed obysician and the burial-transit	dical	d				
	Med	IF FEMALE:				
ath ce	sician/Me	23b. Was decedent pregnant in the past 12 months?	23d. Date of delivery  Month Day Year			
ician: The law requires that the death certific certificate has been signed by the attending rector, page 2 should be detached for use as	ysic	1 ☐ Yes 2 No 9 ☐ Unknown 9 ☐ Unknown 5		Month Bay real		
that the the second sec	/ Phys	Part II. Other significant conditions contributing to death but not resulting in the u	ınderlying cause given in Part I.	23e. Did toba	acco use contribute to t	he cause of death?
quires in sign	d by	aspiration pneumonia, schilor	hrema	1 ☐ Yes	s 2 No 3 Prol	bably 400nknown
aw rec	Completed			24a. Was an	24b. Were auto	ppsy findings available
	mo:			autopsy perform	ed death?	mpletion of cause of 2 □No
ertifica ctor, I	Be	25. Was case referred to medical examiner?	26. Place of Dea	ath (Check only one,		
Physician: r this certific	၉	1 ☐ Yes 2 ☑ Np Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatie		T	nce 6 ☐ Other (Specia	fy)
Jing F	ion:	27. Manner of Death  1 ✓ Natural 5 ☐ Pending  28a. Date of Injury (Month, Day, Year)  28b. Time of Injury	of 28c. Injury at Work?  M 1 □ Yes 2 □ No	28d. Describe hov	v injury occurred	
vittend death ctor: y the	ficat	2 Accident investigation 3 Suicide 6 Could not be determined edge.		28f. Location (Stre	eet and Number or Run	al Route Number.
after Dire	Certification:	4 Homicide determined building, etc. (Specify)	,	City or Town,	State)	,
ospita hours mera ly fille		29a. Certifier the certifying Physician: To the best of my knowledge, dea				
To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	(Check only one)  2  Medical Examiner: On the basis of examination and/or in and manner stated.				
To t With To t	Σ	29b. Signature and title of certifier	29c. License number D63183	29	d. Date signed (Month,	
		1.000000			12/22/08	
B		30. Name and address of person who completed cause of death (Item 23a) (Type, VIJAY SHRI KANNAN 7503 SURRA	1	M -WD	20735	
Sta Registra		31. Date filed (Month, Day, Year)  SEC 2 4 2008  32. Registrar's Signature	Carle			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2008 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** G. FELDMAN 28, 2008 December 22:54 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth March 2, 1922 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours Min 1 □ M 2 🔽 F Pennsylvania 177-14-6208 86 Yrs Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ral", or items 23a or 28a-f show Maryland Silver Spring Montgomery 1 ☐ Yes 2 No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 20906 1 Marigold Court United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status be filed within 72 hours after 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ Specify. Specify: White 3 Widowed 4 □ Divorced 'natural", Completed other traumatic event, the Wadical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Housewife own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hyman Coff Bessie Wolushin ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a item 27 is Robert Silverman -son 1 Marigold Court Silver Spring, Maryland 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State jo. permit. Pages
Department of
Important: If it
any injury or o 1 Burial 2 □ Cremation 3 □ Removal from State Baltimore National Cem. 12/31/2008 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Bonalad V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ongestion disease or condition resulting in death) /Medical Due to (or as consequence of): Examiner Myocardial Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Our to (or as a consequence of): burial-tran Division of Vital Records, P.O. Box 68760∑ Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) ned by the a detached f 9 Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No certificate has autopsy perform 2 No 1 ☐ Yes Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ⊟ Yes 😂 🖽 Śuo patient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) this Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death After t 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 24 hours after death. Funeral Director: A 2 Accident 1 ☐ Yes 2 ☐ No completely filled in by the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

M

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 cm

nda

MO

32. Registrar's Signature

07966

MO

12/30/2008

State of Maryland / Department of Health and Mental Hygiene For State Registrar -Reg. No. 2008 43125 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Matthew John Ganczarski 9:35 P M 31, December 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 33 Amanada Drive Washington Smithsburg If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5 Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Min. Days 1 √M 2 □ F Months Hours 149-05-2260 Yrs 88 1920 New Jersey Director 1, Aug. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show e filed within 72 hours after death with the Maryla al Hygiene, i other than "natural", or items 23a or 28a-f show vent, it without the word, it will not went, it will not a went. Smithsburg 1 √Yes 2 No Director Maryland Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 33 Amanda Drive 21783 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 → No Specify: 2 Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Line Releif Motor Company 12 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) Be Ludwika Wrazien Jan Ganczarski 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 33 Amanda Drive Smithsburg, Maryland 21783 (Wife) Marie F. Ganczarski 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State January 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory Smithsburg, Maryland 4, 2009 21. Signature of Funeral Service License 22. Name and Address of Facility J.L. Davis Funeral Home YAVIS MO1414 12525 Bradbury Ave. Smithsburg, Maryland 21783 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) disease End stage renal **Physician** /Medical Due to (or as a consequence of): Examiner Grive Failuse to Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner It ypertension The law requires that the death certificate be executed nding physician and use as the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery atten for us 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) of Vital Records, P.O. the detached 9 Unknown 9 Unknown signed by 1 I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဥ filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred Division 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1/2/09 MD DOO lole !! le 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STREET, MD 368 MILL Hagerstown, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dech. 31, Day 2008 Year **Physician** Karl Henry Graf /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Peninsula Regional Medical Ctr. 5 Social Security Number 6. 90x 7. Age (In yrs. last birthday) Sa 8. Date of Birth (Month, Day, Year) dicomico 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 ☐XM 2 ☐ F 155-24-9071 90 31. 1918 Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10b. County items 23a or 28a-f show ner must be notified at Wicomico Salisbury 1 X Yes 2 □ No Director MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21801 USA 309 Ohio Ave. Funeral 14. Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 XYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 0 1 □ Yes 2X No Specify: white Specify: þ 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 H.S. grad College (1-4or 5+) Ministry the Episcopal Priest 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Carl Graf Nettie Louella Hiscock ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Rev. Lucilla L. Graf / wife 309 Ohio Ave., Salisbury, MD 21801 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ Removal from State Md Eastern Shore Veteran's 1/7/08 Hurlock, MD 4 Donation 5 Other (Specify) Cemetery
22. Name and Address of Facility 21. Signature of Funeral Service Licen (auch fr Moore Funeral Home, P.A., 12 S. 2nd St., Denton, MD 21629 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) year-/Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine physician and s the burial-trans Due to (or as a consequence of): Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specity) 9 Unknown 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☑ Mo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed′ 1□ Yes 2☑ certificate After this certification funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Inpatient 1 | Yes 2 | 1√0 2 R/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Hatural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760. the Hospital or Attending Physician; Director within 24 hours at er To the Funeral Dire

Baltimore, Maryland 2121

State

Registrar

DHMH 17 Rev 1/2001

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifie

Villiam

and manner stated.

bins

MiD

30. Name and address of person who comple ed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December 22, 2008 **Physician** Sandra Hinnant 11:35 P.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Hospice Care Center Towson Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 9. Birthplace (State or Foreign | Months | Days | Hours | Min. | February 27,1954 | North Carolina 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 TF 217-62-1764 54 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ite Medical Examinat he netified an once. Director 1 ☐ Yes 2 ☐ No Maryland Baltimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 4457 Old Frederick Road 21229 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Never Married 2☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Black Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th grade College (1-4or 5+) Domestic Engineer Housekeeping 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Buck Renfrow Sophie Hinnant မ 19a. Informant's Name/Relationship (Type. Print)
Corrine THomas (SIster) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 4457 Old Frederick Road Baltimore, Maryland 21229-2188 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ₺ Burial 2 ☐ Cremation 3 ☐ Removal from State Rest Haven Cemetery Dec.31,2008 Wilson, North Carolina 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Marshall's FUneral HOme, Inc. A Service 21. Signature of June 4217 9th Street, N.W. Washington, D.C. 20011 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ensi NO disease or condition resulting in death) /Medical Due to (or as a consequence f): **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ✓ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed?
Yes 2 No certificate 2 XNo 1 □ Yes 1 ☐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify Dyreci 1∐Yes 2∐\*No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ After this funeral of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director;
completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) und 30. Name and address of person who completed cause of death (Item 23a) (Type, Print).

11) A-R. Ley G-MC 6701 N-Charles St. 6 mine Date filed (Month, Day, Year) State DEC 3 0 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Reg. No. 2008 43128 For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2008 Year **Physician** Month 21, 8:50 P M DEC. ROBERT HARMON Ē /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Frederick Golden Living Frederick If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**∑** M 2□ F Months Days Director 193-16-5903 85 FEB. 1, 1923 Pennsylvania Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 ☑ No Director Maryland | Frederick Frederick 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 6955 Regents Ct. United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify: ۵ Specify: White 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Finance Officer Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lewis Harmon ပ Dorothy Tishue 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5519 Woodlyn Rd./ Frederick, MD Christine Patterson / Daughter 21703 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Stauffer Crematory 12/23/2008 Frederick, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike/Frederick, MD 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Lolon Physician Can(fr disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Dav Year 5 Other (specify) Division of Vital Records, P.O. 1 Tyes 2 TNo 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ Ho 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? After t 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MM 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) shah 0 31. Date filed (Month, Day, Year) 32. Registrer's Signature State **DEC 23** 2008 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2008 20. 1:52a Luther E. Horine Jr. December /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 34 East George Street Frederick Walkersville 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ₺ M 2 🗆 F Maryland Director 218-38-1682 68 Jan. 16,1940 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County show th and Mental Hygiene. ?7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Exam net such to mutthed at Director 1K Yes 2 □ No Walkersville Maryland Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 21793 34 East George Street United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐Yes 2K No Specify <u>Ş</u> Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Pyro Technician Fireworks 17 Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ Louise Saylor Luther E. Horine Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any Injury or other trau once. 34 East George Street, Walkersville, Maryland 21793 Patricia A. Horine/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/23/2008 Glade Cemetery Walkersville, Maryland 22. Name and Address of Facility Stauffer Funeral 1621 Opossumtown Homes Pike, P. A. Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** 20110 ( 7 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner D(7U-Sequentially list conditions Due to for all a consequence of Physician/Medical Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed thours after death. Funeral Director: After this certificate has been signed by the attending physician and burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, led by the attending physician detached for use as the burial the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown signed by I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ cate has been signated by page 2 should b 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? 25. Was case referred to medica examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a 29a. Certifier 🕁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D146 2C 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gregory P. Rausch MD 501 West 7th Street, Frederick, Maryland 21701 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar Score H. Goods

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 28, Month **Physician** December 2008 0631 Aleksandra Maria Hofmann /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Port Deposit 86 Hawley Road Cecil If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Feb. 27 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Year) 1945 Days Hours 1 ☐ M 2127 F 218-42-6700 Director Maryland 63 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State show notified at 1 ☐ Yes 2X No Maryland Ceci1 Director Port Deposit -28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or. april july or other traumatic event, the Medical Examiner must be none. 21904 86 Hawley Road U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Never Married Married 1 ☐ Yes ZXXNo If Yes, Give Year or Dates: 1 ☐ Yes 2√XNo Specify. þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Personal Residence Homemaker Twelve Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Melvin J. Czyryca Helen Broczkoska 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 86 Hawley Road, Port Deposit, Maryland <u> William J. Hofmann(Husband)</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial XXCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) West Chester, 12/29/08 R.A.Ferris & Co., Inc. Pennsylvania 21. Signature of Funeral Service Licentee 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903-0766 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause op each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Dreas **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed Due to (or as a consequence of): physician as the burial-1 Physician/Medical attending p use as IF FEMALE yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month 5 ☐ Other (specify) certificate has been signed by the rector, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2XNo 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed 2 No 1☐ Yes 2 No 1 🗌 Yes or Attending Physician: After this certification, property of the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation (Month, Day Year) Injury 1 Natural 2 Accident 1 TYes 2 TNo 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Division or Vital Records, P.O. Box 68760, within 24 hours after death.

To the Funeral Director: A completely filled in by the fi To the Hospital

29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and little of certifier 29c. License number 29d. Date signeid (Month, Day, Year) Mame and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature DEC 3 0 2008

State Registrar

5

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** DAVID LEE HARRIS, JR. 2008 5.46AM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE GENESIS ELDERCARE BALTIMORE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday **Funeral** Days Months 1**X** M 2□ F 56 04/26/1952 NORTH CAROLINA Director 242-94-8852 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 XNo BALTIMORE Director MARYLAND BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21220 USA 643 W. KINGS WAY Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Yes 2 No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 X No Specify: BLACK þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) MAINTENANCE TECHNICIAN APERTMENT SERVICES 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MELISSA WILLIAMS DAVID LEE HARRIS, SR. ျ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BRENDA HARRIS / SPOUSE 643 W. KINGS WAY, BALTIMORE, MARYLAND 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If it any Injury or o 1 

Burial 2 □ Cremation 3 □ Removal from State CLARKS UNITED METH. 01/03/09 BEL AIR, MARYLAND 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility LISA SCOTT FUNERAL HOME, South - Coloma 552 LEWIS STREET, HAVRE DE GRACE, MD 21078 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No 24a. Was an autopsy perform 1 Yes 2 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA

**Physician** /Medical Examiner lor Attending Physician: The law requires that the death certificate be executed and burial-trar Division or Vital Records, P.O. Box 68760, physician

28a-f show

ò

items 23a

Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. Int. If item 27 Is marked other than "natural"; or ite

item 27 other t

Baltimore, Maryland 21215-0036

traumatic event, the Medical Examiner must be notified

funeral director, Certification: To filled in by the

this

Atter

after death

24 hours a Hospital

within 2.

Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Injury

1 Natural 2 Accident 3 ☐ Suicide

4 Homicide

29a. Certifier

5 Pending investigation 6 □ Could not be determined

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated.

completed caus

1400

f death (Item 23a) (Type, Print)

28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

SICION

29c. License number

29d. Date signed (Month, Day, Year)

Rockulle MDZxf52

State Registrar

Medical

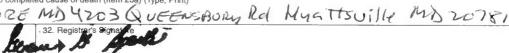
30. Name and address of person who DO 31. Date filed (Month, Day, Year) **DEC 31** 

932 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 10e, per FH 9889 3/13/09 TT State of Maryland Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** DECEMBER 23, 2008 253 PM **JOHNSON** MARY ANN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE ST. THOMAS MORE NURSING &REHAB HYATTSVILLE | Trunder 1 Year | If Under 24 Hrs. | 8. Date of Birth | Min. | Months | Days | Hours | Min. | 04-28-1940 Social Security Number . Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 🔀 F WASHINGTON, DC 68 Director 578-54-1749 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a State 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Examirer must be notified at 10d. Inside City Limits **Funeral Director** 1√2 Yes 2 □ No PRINCE GEORGE HYATTSVILLE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20781 U.S.A. 5808 42nd AVE #223 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify ≥ Specify: BLACK 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th CARETAKER GOVERNMENT 7 is marked other traumatic event, 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) MELVIN WESLEY JUDKINS EVELYN OVERS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7963 CENTRAL PARK CIRCLE ALEXANDRIA, VA 22309 DWAYNE ROBERTSON/SON item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State = 5 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once, RIVERDALE CREMATORY 112-31-2008 RIVERDALE, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility JB JENKINS FUNERAL HOME 21. Signature of Fun, al Service Licens 7474 LANDOVER RD LANDOVER, MD 20785 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) LEFT BREUSTCANCER WITH Physician months /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, loading to initiodiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year Pregnant at time of death 5 Other (specify) ed by the 9 Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 No 1 □ Yes 1 ☐Yes 2 ☐ No Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 K Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2⊠No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 🔀 Natural 5 Pending To the Hospital or Attendi within 24 hours efter dea.h. To the Funeral Director A completely filled in by the fi dea.h. 1 □Yes 2 □No 2 Accident investigation 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1🙇 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DECEMBER Z3 2008

State

State 31. Date filed (Month, Day, Year, Registrar DEC 3 0 2008



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 1323 M ANNA GERTRUDE FISHER JUSTICE 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death TENINGUA REGIONAL 54456414 Wiennico If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 1 □ M 2 🗗 F Months Days 223-62-6499 74 6/20/1934 Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No VA Accomack Oak Hall 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 8089 Lankford Highway 23416 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 💆 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2X Married 1 ☐Yes 2X No If Yes, Give Year or Dates: Specify. Specify: white 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hairstylist Beautician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Paige Decato Fisher Ellen Colbourne 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Justice (husband) 8089 Lankford Hwy., Oak Hall, VA 23416 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Downing's Cemetery 12/28/2008 Oak Hall, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funer Service Licensee Holloway Funeral Home, Professional Association 103 Linden Ave., Pocomoke City, MD 21851 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final multiple mycloma Teg disease or condition resulting in death) Due to (or as a consequence of): eptie Shock Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Introcrancel Due to (or as a consequence of) Paneytopenia a weeks IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 ∐Yes 2 MarNo 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending

Physician/Medical Completed by

Be

Certification: To

cal

Examiner

**Physician** 

/Medical

**Examiner** 

Director

Funeral

ģ

Completed

Be

**Funeral** 

Director

show

ed other than "natural", or items 23a or 28a-f show event, the Medical Evandor must be redflied at

marked other than

1 and 2 should be fill Health and Mental H tem 27 is marked ott

permit. Pages 1 and Department of Health Important: If Item 27 any injury or other t

Physician

/Medical

Examiner

physician and s the burial-transit

attending pl

signed I

page 2 s

director,

funeral

filled in by the

sompletely

this

24 hours after death.

within 2

BA 6

Hospital

or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760.

Baltimore, Maryland 21215-0036

1 ☐Yes 2 No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

(Check only 29b. Signature and title of certifier

2 Accident

4 ☐ Homicide

3 ☐ Suicide

29a. Certifier

29c, License number DO014314

29d. Date signed (Month, Day, Year) Die 25. 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PANFIT P. KLUa. 100 Eset Consil atuit, Lolibury, ma 21801

State Registrar

31. Date filed (Month, Day, Year)

investigation

6 Could not be determined



DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JAN 132009

		Fleas	se type of Print in					_	ibic.			
		. For	State of Marylar	nd / Depa	artment of H	lealth and N	1ental Hygi	ene		10105		
	1	State Registrar		Cer	tificate of	Death	Re	g. No. 2 (	JUB	43135		
		1. Decedent's Name (First, Middle	e, Last)				Date of Death     Month	Day	Year	3. Time of Death		
nysicia Madia	_	Patti E.	Kearney				Decembe			20:27 M		
Medic	_	4a. Facility Name (If not institution	n, give street and number)		4b. City, Town, o	r Location of Death		4c. County	y of Death			
		Southern Mary	land Hospital		Clinto	n		Princ	ce Ge	orge's		
neral		5. Social Security Number		s. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	9. Birthp	place (State or Foreign ntry)		
ector		578-78-5073	1□ M 2 <b>X</b> F 51	Yrs.			Sept 3,	1957	Wash	ington, DC		
		Usual Residence of Decedent	100.0	City. Town or Lo	nation				11	10d. Inside City Limits		
Fr snov	tor	10a. State 10b. County 10rince	e George's	Temple						1⊠Yes 2 No		
1288	Director	10e. Street and Number		10f. Zip Code		10	g. Citizen of	What Cour	ntry?			
23a o		7010 Westches	ster Drive		20748			tes				
tems	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13. \	Was Decedent of I f Yes, specify Cub	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	<sup>can Indian,</sup> etc. <b>African</b>				
Examir	þ	1 ☐ Never Married 2 ☐ Marr 3 ☐ Widowed 4 🙀 Divorced	1 ☐ Yes 2 █ No If Yes, Give Year or Dates:	1	I∐Yes 2⊠XNo	Specify:		Specia	fy:	American		
dical	etec	15. Decedent	t's Education st grade completed)	16a. Deced	dent's Usual Occup kind of work done	oation during most of work d)		6b. Kind of E	Business/In	dustry		
nan e Me	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)					Priva				
it, it	ပိ	17. Father's Name (First, Middle,	2 years	Comp	outer Tec		e (First, Middle, M					
rked of	To Be	Hosea Lindsey Mordelle Robinson										
Important: If item 27 is marked other than "natural", or items 23a or 28a4 show any injury or other traumatic event, it a Madical Examinar must be nullified at once.	•	19a. Informant's Name/Relationship (Type. Print)  John Robinson - Son  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co. 7010 Westchester Drive Temple Hills, MD 20										
othe		20a. Method of Disposition	20b.	Place of Dispo	sition (Name of natory or other pla	ce)	Date 2	20c. Location	- City or To	own, State		
nt: If		1 ☐ Burial 2 🔀 Cremation 4 🗓 Donation 5 ☐ Other (S	3 Li Removal from State	e's Cre			30, 2008		Cli	nton, MD		
e i i		21. Signature of Funeral Service	Licensee	0/10		ess of Facility St				•		
E E 8		MONUM X	Summer III	40	001 Benni	ng Road,	NE Washi	ngton	DC :	20019		
		23a. Part 1. Enter the disease, or	complications that caused the dea	ath. Do not ent	er the mode of dy	ng, such as cardiac	or respiratory arre	est,		Approximate Interval Between		
ician		Immediate Cause (Final disease or condition	SEPSIS							Onset and Death		
dical		resulting in death)	Due to (or as a conse	equence of):								
niner			b									
#	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conse	equence of):								
trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	с									
urial-	Ä	resulting in death) Last	Due to (or as a conse	equence of):								
g physician and as the burial-transit	edical		d									
as as	ĕ											

Phys /Me Exa

Dir

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

Physician/N

þ

Be Completed

Medical Certification: To

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlat-transit completely filled in by the funeral director, page 2 should be detached for use as the burlat-transit

Division of Vital Records, P.O. Box 68760,

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknow

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death

4 Pregnant at time of death 9 Unknown

3 Ectopic pregnancy

5 ☐ Other (specify)

23d. Date of delivery Month

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably

CANCER BREAST

24a. Was an autopsy performed? Yes 1 □Yes

24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 ☐ Yes

25. Was case referred to medical examiner? 27, Manner of Death

29a. Certifier

5 Pending investigation

Inpatient 28a. Date of Injury (Month, Day, Year)

2 ER/Outpatient 3 DOA 28b. Time of Injury 28c. Injury at Work?

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

Matural 1 ☐Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

Kassahun

D0055973

12-24-08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7503 Surratts Road Clinton, MD 20735 Zeleke Kassahun, M.D. 31. Date filed (Month, Day, Year)
DEC 3 0 2008

State Registrar 32. Registrar's Si

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year 22, 5:50 December 2008 William Edward Keith 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Frederick 11651 Browningsville Road Ijamsville If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 1 X M 2 □ F Sept 13, 1938 Maryland 70 215-36-5032 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. Counfy 1 ☐ Yes 2 X No Maryland Frederick Ijamsville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21754 USA 11651 Browningsville Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2X No Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 owner/operator lawn service 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William Howard Keith Frances Louise Beetz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21754 19a. Informant's Name/Relationship (Type. Print) 11651 Browningsville Road, Ijamsville, Maryland Shirley Keith, wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Metropolitan Crematory 12/22/2008 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Molesworth-Williams Funeral Home 21. Signature of Funeral Service Licenses 26401 Ridge Road, Damascus, Maryland 20872 Approximate Interval Between Onset and Death En er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, k, or heart failure. List only one cause on each line. 2 weeks Unknown Date of delivery Month Day Year 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

**Physician** /Medical **Examiner** 

permit. Pages 1
Department of F
Important: If Ite
any injury or ot

**Physician** 

/Medical

Examiner

Director

Funeral

Completed by

Be

ပ

**Funeral** 

Director

Pages 1 and 2 should be filed within 72 hours after death with the Manyland nent of Health and Mental Hygiene. and: If Item 27 is marked other than "natural", or items 23a or 28a-f show ant: If Item 27 is marked other than "natural", or items us be notified at ury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

and physician as attending asn signed by the a

that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

or Attending Physician:

10

After

Examine Physician/Medical þ Completed page Be funeral Certification: ours after death.

neral Director: A
filled in by the fu To the Hospital o within 24 hours aff To the Funeral D

Immediat Cau e (Final disease or an ition resulting in death)	a. Congestive Heart Failure  Due to (or as a consequence of):
Sequentially list conditions, if any, leading to fining list cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Arteriosclerotic Cardio-Vascular Disease  Due to (or as a consequence of):  Due to (or as a consequence of):
IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf pregnancy  1 Live birth 2 Petal death 3 Ectopic pregnancy  4 Pregnant at time of death 5 Other (specify)

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No performed? 1∐ Yes 2 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 2X No 1 | Inpatient 2 ER/Outpatient 3□ D0A 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

29b. Signature and title of certifier mith, MD

Cerebro-Vascular Disease

29c. License number

D10587

29d. Date signed (Month, Day, Year) December 23, 2008

1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

516 Trail Frederick, Maryland 21701 George I. Smith, Jr. Avenue, 32. Registrar's Signature 31. Date filed (Month, Day, Year)

State Registrar

**DEC 2 3** 

State of Maryland / Department of Health and Mental Hygiene, 43137 For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** Month Yeon Jung Kim Dec. 2008 4:00 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Gilchrist Hospice Care Towson Baltimore 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 1 □ M 2 🕱 F Nov 8, Director 220 17 1474 41 1967 South Korea Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location d other than "natural", or items 23a or 28a-f show event, the "actical Expression" rust be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 X No MD Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8365 Tamar Drive Apt 837 21045 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 28 Married Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐Yes 2 No Specify: <u>۾</u> Specify: 3 Widowed 4 Divorced Asian Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygic Important: If item 27 is marked other I any Injury or other traumatic event, In 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Young Kwon 2 Young Hee Choi 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jung W. Kim/Husband 8365 Tamar Drive Apt 837 Columbia, MD 21045 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Ardent Crematory 12-26-2008 | Hanover, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. M01044 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 605 tR10 disease or condition resulting in death) months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physiclan: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical as the IF FEMALE: for use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 

Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 X No Month Day Year 5 Other (specify) be detached 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 🔁 No 3 Probably 4 Unknown page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No has autopsy certificate 2 100 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 0301 C 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural Accident 5 | Pending investigation 1 ☐ Yes 2 ☐ No after death Director: 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide 24 hours a \*\*Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ical 29a. Certifier (Check only within 2 To the I 29d. Date signed (Month, Day, Year)
December 25 2008 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TOWSIN MD wartes ST W) 6701 N.C Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygienes O O O

			for State Registrar		State of Mi	ai yiai ic	Cei	rtificate of	Death	vientai ny	Reg. N		4313	90
	Physici	an	1. Decedent's Name (Firs	t, Middle, Las	st)			-		2. Date of De	eath	)av Year	3. Time of Deat	h
	/Medi		Elena		yevna	Khus	nutdi	nova		Decemb	er :	26, 2008	0530	М
	Examir	er	4a. Facility Name (If not in		,			4b. City, Town, o	or Location of Death	1		c. County of Deal		
app of the	Europel		Suburban Ho  5. Social Security Number	~		e (In vrs. la	st birthday)	If Under 1 Year		8. Date of Bi		Montgome:		eian
	Funeral Director		218-79-7453 Usual Residence of Dece	3 1	□м 2√Д F	32	Yrs.	Months Days	Hours Min.	8. Date of Bi (Month, D Dec • 14	ay, Yea •19	76 US	hplace (State or Fore untry) SR	
	yland yland			County		10c. City,	Town or Lo	cation					10d. Inside City Lim	nits
	a-fsh	ctor	MD Mc	ntgome	ery	Rock	ville						1∐Yes 2√∑	No
	with the Maryland a or 28a-f show Locnofffied at	Dire	10e. Street and Number					10f. Zip Code			10g. 0	Citizen of What Co	untry?	
	s 23a	eral	2008 Baltin	ore Ro			14-	20851				ssia		
21215-0036	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or items 23a or 28a-f show sht, the Medical Everginer must be notified a	d by Funeral Director	11. Marital Status  1 □ Never Married 2  3 □ Widowed 4 □ □	ivorced	12. Was Decedent Armed Forces? 1 _Yes 2_1 If Yes, Give X Year or Dates:		1	Was Decedent of I If Yes, specify Cub 1 □ Yes 2 ☑No	Hispanic Origin? (S an, Mexican, Puerti Specify:	pecify Yes or No o Rican, etc.)	0-	14. Race - Ame Black, White Specify: W		
15-(	"natural",	lete	15. D (Specify oni	ecedent's Ed ly highest gra	ucation de completed)		16a. Dece	dent's Usual Occup kind of work done	pation during most of worl d)	king	16b.	Kind of Business/	ndustry	
12	filed within Hygiene. other than	Completed	Elementary/Secondary	(0-12)	College (1-4or 5	j+)		naker	a)			√n Home		
<b>d</b> 2	filed Hygi sther ent, t	Be Co	17. Father's Name (First,	Middle, Last)			nomei	naker	18. Mother's Nam	ne (First, Middle				
lan	ould be f Mental arked o atic eve	To B	Valeriy Ber	yozkir	l.				Nuriya :	Saidkho	djae	eva		
ary	and N		19a. Informant's Name/R						and Number or Ru					
Σ	s 1 and 2 should be filed within 72 hc f Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the Medical		Rafael Khus		ov (husb				e Rd. #E					
Baltimore, Maryland	Page: nent o ant; If		20a. Method of Dispositio 1 ☐ Burial 2 ☐ Crei 4 ☐ Donation 5 ☐ C	mation 3 🗆			sapeal	sition (Name of natory or other pla ke Cremat	ory 2	Date 27,		Location - City or ltsville	,	
Balt	permit. Departi Importa any injl		21. Signature of Fune and	Service Licen	see	M00		2. Name and Address 933 Gist	ess of Facility Rate Ave. Si	pp Fune lver Sp	ral ring	& Cremat g, MD 209	ion Ser.	
	Physician /Medical		23a. Part 1. Enter the disc shock, or heart failu Immediate Cause (Final disease or condition resulting in death)	ease, or comp re. List only o	one cause on each line.  a. <u>Metast</u>	ne. ic Ga	stric	er the mode of dyi	ng, such as cardiac	or respiratory a	arrest,		Approximate Interval Between Onset and Death 6 months	
4	Examiner				Due to (or as	a conseque	ence of):							
	P =	ner	Sequentially list condition if any, leading to immedia	s, te	b. Due to (or as	a conseque	ence of):							-
5	icate be executed physician and s the burial-transit	Examiner	Cause (Disease or injury that initiated events		C									
68760,		Ĕ	resulting in death) Last		Due to (or as	a conseque	ence of):							
87	cate I physie the b	dica			d				<del></del> _					
O. Box	death certif e attending d for use as	by Physician/Medical	IF FEMALE: 23b. Was decedent pregr in the past 12 month 1 □ Yes 2 No 9 □ Unknown	nant s?	23c. If yes, outcome 1  □ Live birth 4  □ Pregnant a 9  □ Unknown	2 Fetal o	death 3 □	Ectopic pregnand Other (specify)	cy			23d. Date of dell Month	very Day Year	
Э,	equires that the sen signed by the ould be detache	y Ph	Part II. Other significant	conditions co	ontributing to death be	ut not result	ting in the ur	nderlying cause giv	ven in Part I.	23e. Did 1	tobacco	use contribute to	the cause of death?	
Division of Vital Records,	equire en sig ould b									1 🗆	Yes :	2 <b>X</b> No 3□ Pr	obably 4 🗌 Unknow	√n
ecc	law re ras be	Completed								24a. Was auto	an	24b. Were au	topsy findings availal ompletion of cause of	ole
Ξ.	The cate h	Son								perfo 1 □ Yes	rmed? 2 <b>X</b> N	death?	2 □No	"
Vita	ician certifi ector,	Be	25. Was case referred to examiner?	-	Haspital:			Lou	26. Place of Dear	th (Check only o				
of	Phys	6	1 ☐ Yes 2 No 27. Magner of Death				R/Outpatien 28b. Time of	t 3 DOA Oth	4 LI Nursing He			6 ☐ Other (Spec	cify)	
on	ding th. After fune	tion	- V	Pending investigation	28a. Date of Inju (Month, Day	v, Year)	Injury	Wor	yat k?  Yes 2 □ No	28d. Describe	now inji	ury occurred		
/isi	Atten r deat sctor: by the	ifica	3 ☐ Suicide 6 ☐	Could not be determined		ıry - At hom	ne, farm, stre		103 2 110	28f. Location (	Street a	and Number or Ru	ral Route Number.	
Ö	al or s afte al Dire	Certification: To	4 ☐ Homicide	dotermined	building, etc	c. (Specify)				City or To	wn, Sta	te)		
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 s.	Medical (	29a. Certifier 1 1 2 C (Check only one) 2 N	ertifying Phyledical Exam	ysician: To the best of iner: On the basis of and manner sta	r examinatio	ledge, death on and/or in	n occurred at the ti vestigation, in my	me, date and place opinion, death occu	, and due to the rred at the time,	cause date a	(s) and manner as nd place, and due	stated. to the cause(s)	
	To the within to the complex c	ž	29b. Signature and title of	certifier	7			29c. Licens	se number		29d. D	ate signed (Month	, Day, Year)	
	8			50	The state of the s			D4:	3083		Dece	ember 26	2008	
			30. Name and address of				, , , , .	,	11.000					
	-01		George A. S		200 Degistre	r'a Cianatu			. #300 Ro	ckville	, M	20850		
	Sta Registr			2 9 20		J. J.	600	wie						

State of Maryland / Department of Health and Mental Hygien 208 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day **Physician** King Donna 4:35p <sup>M</sup> Τ., 25 2008 December /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cecil 965 Lombard Rd. Rising Sun If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 1□M 21 F Director 577-32-6061 82 3-26-1926 VA Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show "natural", or items 23a or 28a-f shovedical Examiner must be notified at 1 Yes 2 No Director MD Cecil Rising Sun 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21911 USA 965 Lombard Rd. death by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. is 1 and 2 should be filed within 72 hours after of thealth and Mental Hygiene. Item 27 is marked other than "natural", or item other traumatic event, the Medical Examinean other traumatic event, the 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 TNo Specify. If Yes, Give Year or Dates: 3X Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Staley Anderson Flora Halsey 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1478 State Rd. Oxford, PA 19363 Angela Weaver 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Nottingham Missionary 29-08 permit. Pages 1 Department of P Important: If Ite 1 Burial 2 □ Cremation 3 □ Removal from State any injury or Nottingham, Baptist Cemetery 22. Name and Address of Facility 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lic Edward L. Collins Funeral Home Oxford, 23a. Part1. Enter the disease, or complican insithat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on pact line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical as a consequence of Examiner 100 Sequentially list conditions, Due to (or as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 No 1 Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month 5 ☐ Other (specify) been signed by the s 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes No 24a. Was an this certificate has ral director, page 2 autopsy 1□ Yes 2 No or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \sum Nursing Home 2 No 1 ☐ Yes P 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation Injury 1 Natural 2 ☐ Accident 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: / 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			State Amend Item 2	State of M	aryland	1 Depa 388 02 Cer	rtmer tificat	is of H	ealth ar <i>eath</i>	nd Me	ental Hyg	giene 20	08	43140	}
			Decedent's Name (First, Middle, Last)	_							2. Date of Dea Month	th	Voor	3. Time of Death	
	Physicia /Medic		TERRY	Eugeno	e	<r< td=""><td>016</td><td>OHT</td><td></td><td></td><td>12</td><td>30 3</td><td>800</td><td>1341 M</td><td></td></r<>	016	OHT			12	30 3	800	1341 M	
	Examin		4a. Facility Name (If not institution, give s						Location of [	Death		4c. County	of Death		
			The Johns Hopkins Hos  5. Social Security Number 6. Sex		an /In urn Ir	ast birthday)	Balti If Unde	more	City If Under 24	4 Hrs. Is	3. Date of Birth	,	9 Birthol	ace (State or Foreign	_
	Funeral Director			M 2□F	71	Yrs.	Months	Days		Min.	(Month, Day Jan. 2	, Year)	Countr	ryland	
			Usual Residence of Decedent								Jan. 2.	7,1557			
	show at	L	10a. State 10b. County		10c. City	, Town or Lo							10	od. Inside City Limits  1 ☐ Yes 2 ☐ No	
	e Ma Ba-f s	Director	Maryland Washin	gton	L _	K	eedys		.e				21		
	/ith th	Dire	10e. Street and Number	- ' '			10f. Zip	-Code 2175	.6		1	Iog. Citizen of V	/hat Counti	γ?	
	s 23a	erai	19344 Burnside	Briage Ro		13 \	Nas Dece			n? (Speci	ify Yes or No-		e - America	n Indian.	_
	ter de	Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Married	Armed Forces?	?	'	f Yes, spe	cify Cuba	n, Mexican, F	Puerto Ri	can, etc.)		k, White, e		
2	urs al	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:			I ☐ Yes	2 <b>X</b> No	Specify:			Specify	Wh.	ite	
5-0036	be fled within 72 hours after death with the Maryland Hygiene. All Hygiene. Ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	15. Decedent's Edu (Specify only highest grade			16a. Deced (Give	kind of wo	ork done a	luring most c	of working	9	16b. Kind of B	usiness/Ind	ustry	
Z	ithin nan " Med	mpf	Elementary/Secondary (0-12)	College (1-4 or	5+)		00 NOT u	· ·				TI 201	ucks		
2 2	tygier tygier t, the		10 17. Father's Name (First, Middle, Last)				<i>Fabr</i> .	ICall		's Name	(First, Middle,	Maiden Surnan			_
and		Be c	Edward M. Knigh	t						Elsi	e M. M	yers			
Ē	d 2 should be filed within the and Mental Hygiene. 7 is marked other than ", traumatic event, the Med traumatic event, the Med	ည	19a. Informant's Name/Relationship (Typ	oe. Print)		19b. Mailir	ng Addres	s (Street	and Number	or Rural	Route Numbe	er, Cify or Town,	State, Zip	Code)	_
-	0 = 0 = 1		Mary V.P. Knight	(Wife)		19344	Bur	$nsid\epsilon$	Brid	ge R	d. Kee	dysville	e, MD	21756	
ē,	permit. Pages 1 and 3 Department of Health Important: If Item 27 any Injury or other tr.		20a. Method of Disposition	Otata	20b. P	lace of Dispo	sition (Na	me of other place	e) !	Da		20c. Location -	City or Tov	rn, State	
Š E	Page nent c int: if		1 ☐ Burial 2x ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		thsbur				Janu 5, 2	009	Smith	sburg	, Maryland	l
galti	porta porta y Inji		21. Signature of Funeral Service License						s of Facility			avis Fu			
מ	82 5 6 9	_	· Jelle fee.	<u>L</u> avis	MO 14								Mary.	Land 21783 Approximate	<b>}</b>
			23a. Part 1. Enter the disease, or compli- shock, or heart failure. List only on	e cause on each li	ne.					artilac oi	respiratory ai	iest,		Interval Between Onset and Death	
-	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as	D10	PULA	المحا	+127	A	rpe	51				_
	Examiner		1	CEPE	s a consequ	ence on:	JEA	12-	7700	1					
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury					(1-	(()						-
	uted ansit	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events  C												
,	exec an and unal-tr	Ē	resulting in death) Last	Due to (or as	s a consequ	uence of):									
/60,	certificate be executed ding physician and use as the burial-transit	dical		l						<del> </del>					_
ğ	entifica ing ph	•	IF FEMALE:	3c. If yes, outcome	e of pregna	incv						224 Da	to of dolino		
X R Q	ath ce ttendi for us	Physician/M	in the past 12 months?	1 Live birth 4 Pregnant a	2 🗌 Feta	Ideath 3	Ectopic Other (s		/			1	te of delive nth	Day Year	
9	the a	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 🗌 Unknown	at time of de	5401 5	_ Outer (3,	pecny)							
Į.	law requires that the death certificals been signed by the attending place 2 should be detached for use as		Part II. Other significant conditions con	ntributing to death	but not res	ulting in the u	underlying	cause gi	ven in Part I.		23e. Did to	bacco use con	tribute to th	e cause of death?	
Vital Records,	uires signe	q pa	1/PELTENSION								474	<b>6</b> 6 2 <b>X</b> No	3 🗌 Proba	ably 4 🗌 Unknown	
င္ပ	w req	plet	HAPERLIPIDEMIL	ξ							24a. Was a		Were autop	osy findings available inpletion of cause of	
ř	ysician: The law is certificate has b I director, page 2 g	Completed by	6LAUCOMA								perfor	med?	death?	2 🗌 No	
<u> </u>	lan: lan: rtificat ctor, p	Be C	25. Was case referred to medical examiner?					1		of Death (	Check only or	ne)			_
	Physical this cerral dire	2	1 ☐ Yes 2 X No	Hospital: 1 Inpat		ER/Outpatier			4 🗆 Nurs			lence 6 🗆 Oth			_
Ĕ	ding Ph h. After thi funeral	ino iii	27. Manner of Death 1   Natural 5  Pending	28a. Date of Inj (Month, Da	ury ay Year)	28b. Time o Injury	м	28c. Injury Work	yat ⟨? Yes 2		sa. Describe r	ow injury occur	rea		
Division of	Attending Physician: or death. ector: After this certific. by the funeral director,	icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of in	niury - At ho	me, farm, str			165 2 10		8f. Location (	Street and Numi	oer or Rura	l Route Number,	-
2	or Al after Direc	Certification:	4 - Homicide determined		etc. (Specify		, , , , , , , , , ,	,,			City or Tow				
	spital		29a. Certifier 1 XCertifyIng Phys												_
	Fo the Hos within 24 hd Fo the Fun completely	edicai	(check only 2 Medical Exami	and manner s		tion and/or in	vestigatio	n, in my o	pinion, geau	n occurre	ed at the time,	place	and due to	The cause(s)	_
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the f	Ž	29b. Signature and title of certifier		M.			c. License		2		29d. Date signe		0 -	
4			1000	21					-00		!	JECEM	REK	30, 2008	_
	•		30. Name and address of person who co		0	n 23a) (Type,	Print)			IA OOS	orth Wo	Ife St Re	ltimor	e, MD, 21287	7
	Sta	to	31. Date filed (Month, Day, Year)	32. Regist		ture /	/	. 0		JOU IN	O1 111 W	ne ot, De		U, IIID, £1201	-
	عاد Regist		JAN 1320	109 Den	rar's Signat	1. 14	bark	1							

DHMH 17 Rev 1/2001

10

			State of Maryland / Depa 1 - State of Maryland / Depa Registrar Amend#7 . PerFHPGCcr Cer	rtment of Health and I		giene Reg. N <b>?</b> () () {	2 1.311.1		
			Registrar Amend# / . Perrhpgccr  1. Decedent's Name (First, Middle, Last)	inicate of Death	2. Date of Dea	ath	3. Time of Death		
	Physicia /Medic		Betty LONG	***	Month /2	27 O	8 10 Hm		
N. Control	Examin	er	4a. Facility Name (It/hot institution, give street and number)	4b. City, Town, or Location of Death	ana	4c. County of D	CAMERU		
_	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birt	h 9.	Birthplace (State or Foreign Country)		
	Director		579366722 1 M 2 M 5 76 77 Yrs.	monard Baye Heart	07/16/		Wash., DC		
	yland now at		10a. State 10b. County 10c. City, Town or Loc	ation			10d. Inside City Limits		
	e Mar Ba-f sk kiffjed	ctor	Maryland Montgomery Silver Spr				1 Yes 2 No		
	with the a or 2 the no	Funeral Director	10e. Street and Number 2700 Barker Street	10f. Zip Code 20910		10g. Citizen of What USA	t Country?		
	death	nera		Vas Decedent of Hispanic Origin? (S f Yes, specify Cuban, Mexican, Puert	pecify Yes or No		American Indian, Vhite, etc.		
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by	4 Cate of Standard OC Standard   4 C Voc OCT No	☐ Yes 2 🖾 No Specify:	o moun, oto.	Specify: W.			
21215-0036	72 ho "natur dicai	Completed	(Specify only highest grade completed) (Give I	ent's Usual Occupation kind of work done during most of wor OO NOT use retired)	rking	16b. Kind of Busine	ess/Industry		
121	within iene. than	ошр	Elementary/Secondary (0-12) College (1-4or 5+)	ice Clerk		Private			
nd	al Hyg I other	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Nan		Maiden Surname)			
Maryland	Dould to Ment narkect	2	Grantley E. Burch		. Kidwel		As Tis Code)		
Z	nd 2 sh alth and 27 is r r traur	1		g Address <i>(Street and Number or Ru</i> irard St., Apt.					
altimore,	ges 1 a it of Hea if item or othe		1 M Burial 2 Cremation 3 Hemoval from State	natory or other place)	Date	20c. Location - City			
Him	nit. Pa artmer ortant: Injury			1 Cemetery 1/2, Name and Address of Facility	/2008	Suitland,	Maryland		
B	Dep imp any		Jack A. Wilson, M01246  22. Signature of Funeral Service Licensee	dar Hill FH 4111	PA.,Ave	. Suitlan	d, MD 20746		
r.			23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.	1	or respiratory a	rrest,	Approximate Interval Between Onset and Death		
1	Physician /Medical								
	Examiner								
	peq sit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury						
Ć.	execut n and ial-trar	Examiner	that initiated events c						
8760,	cate be executed oblysician and the burial-transit	dical	d						
မ	death certifice attending ph	/Mec	IF FEMALE: 23c. If yes, outcome pf pregnancy			23d. Date of	dolivany		
Box	that the death cer ed by the attendin detached for use	Physician/Med	in the past 12 months?  1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Live birth 2 ☐ Fetal death 5 ☐ 4 ☐ Pregnant at time of death 5 ☐	Ectopic pregnancy Other (specify)		Month	Day Year		
P. 0	nat the d by th etache	Phys	9☐Unknown  9☐Unknown  Part II. Other significant conditions contributing to death but not resulting in the un	darhing anna given in Dart I	220 Did to	ahaasa usa santrihut	te to the cause of death?		
Division or Vital Records,	sign sign d be	ed by				Yes 2 No 3			
eco	e law requ has been je 2 should	Completed	Orinary tract Infection	, Failure	24a. Was	osy prior	e autopsy findings available to completion of cause of		
<u>е</u>	sician: The certificate I rector, page		to thrive		1□ Yes				
ζ	ysicial s certi directo	To Be	25. Was case referred to medical examiner?  1   Yes 2   No   Hospital: 1   Inpatient 2   ER/Outpatien	0.11	ath <i>(Check only o</i> tome 5☐ Besid	<i>ne)</i> dence 6  □Other (3	Specify)		
n 0	ding Phys	Du: T	27. Manne: Death 1 Death 28a. Date of Injury (Month, Day Year) Injury			now injury occurred	, and the second		
isio	Attending Physician: r death. ector: After this certifics by the funeral director, p	icati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 380 Place of injury. At home farm stre	M   1 ☐ Yes 2 ☐ No	28f Location (	Street and Number o	r Rural Route Number,		
<u>≥</u>	s after s after al Director	Certification:	4 ☐ Homicide determined building, etc. (Specify)	ist, lastory, smos	City or Tov		Triare route rumbor,		
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death and manner stated.	vestigation in my opinion, death occur	urred at the time	date and place, and	due to the cause(s)		
	To the within 2 To the comple	Me	29b. Signature and title of certifier	29c. License number		29d. Date signed (M	fonth, Day, Year)		
•	سر		30. Name and address of person who completed cause of death (Item 23a) (Type, I	1943/21		1427	12008		
12	15		30. Name and address of person who completed cause of death (Item 23a) (Type, I NURUL CHOWDHURY, MD 1/15216	DINU DRIVE : 16	PURTON	SVILLE, 1	MD 20866		
	Sta Registi		and manner stated.  29b. Signature and title of certifier  Choward  30. Name and address of person who completed cause of death (Item 23a) (Type, I NURUL CHOWDHURY, MD, 1576)  31. Date filed (Month, Day, Year)  DEC 3 0 2008						

			1 - For State Registrar	State of Ma	ıryland	Depa / Cer	rtment of <i>tificate of</i>	Health and <i>Death</i>	Mental Hy	giene Reg. No	2008	43142	
	Dhusisi		1. Decedent's Name (First, Middle,	Last)					2. Date of De	3		3. Time of Death	
	Physici /Medio		Martin Lee						Dec. 25	, 200	08	7:30P M	
	Examin	er	4a. Facility Name (If not institution,	,				or Location of Dea	tn		County of Death  Calvert		
	Funeral		,	5. Sex 7. Age	(In yrs. las		Solomo If Under 1 Year Months Days	If Under 24 Hrs		rth av. Year)		place (State or Foreign	
	Director		577 46 4629 Usual Residence of Decedent	1½ M 2□F 74	4	Yrs.	monario Bay		April 7			DC	
	yland now		10a. State 10b. County		10c. City, T	Town or Loc	ation				1	0d. Inside City Limits	
	e Mar Ba-f sl	Director	MD Calver	t	St.	Leona	.rd					1 □Yes 27√2 No	
	a or 2	Dir	10e. Street and Number 6056 Bayview R	and			10f. Zip Code 206	85			en of What Cour	•	
	death ms 23	Funeral	11. Marital Status	12. Was Decedent E	ver in U.S.	13. W		Hispanic Origin? (	Specify Yes or No		4. Race - Americ	can Indian,	
5-0036	a within 72 hours after death with the Maryland glene. In than "natural", or items 23a or 28a-f show the Madoel Examiner must be motified at the Madoel Examiner must be motified at	Š	1 X Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?  d 1 □ Yes 2 ☒ No lf Yes, Give Year or Dates:	0		Yes, specify Cul  ☐Yes 2X No		to Rican, etc.)		Black, White, etc.  Specify: White		
	72 ho "natur	etec	15. Decedent's (Specify only highest	Education grade completed)	1	I6a. Decede	ent's Usual Occu	ipation during most of wo	rking	16b. Kin	d of Business/In	dustry	
121	within jene.	Completed	Elementary/Secondary (0-12)	4 College (1-4or 5+	C-	ertif:	o NOT use retir ied Prop	erty Man	ager	Rea:	l Estate	<b>!</b>	
פר	othe ent,	Be C	17. Father's Name (First, Middle, La	ıst)				18. Mother's Na	me (First, Middle	, Maiden S	Surname)		
yland	2 should be filed n and Mental Hygi 'is marked other raumatic event, I	10	Bertram M. Luc						hy Kampf				
Z Z	d 2 sh th and t7 is m traum		19a. Informant's Name/Relationship		1			t and Number or F			Town, State, Zip	Code)	
ē,	s 1 an of Hea item 2		Bettejane L. Mid 20a. Method of Disposition		20b. Plac	e of Dispos	Beach Dr ition (Name of atory or other pla	ive St.	Leonard Date	20c. Loc	20685 cation - City or To	wn, State	
<u>E</u>	Page ment c ant: If ury or		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe			onal	Cremato	ry  12/2	7/2008		s Church		
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic es once.	8)	21. Signature of Funeral Service Lie	ensee Military				ess of Facility ${ m J}_{ m O}$			s Sons, gton, DO		
			23a. Part 1. Enter the disease, or co shock, or heart failure. List or	omplications that caused to	the death. I	Do not ente	r the mode of dy	ing, such as cardia	c or respiratory a	rrest,		Approximate Interval Between	
1	Physician	1	Immediate Cause (Final disease or condition resulting in death)	Prosta	ate Ca	ancer						Onset and Death	
	/Medical Examiner		recalling in dealiny	Due to (or as a	consequen	ice of):							
	p ±	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b Due to (or as a	consequen	ice of):						·	
7	recuter and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	с		0				- ,			
00/00	ficate be executed physician and is the burial-transit	alE	, , , , , , , , , , , , , , , , , , , ,	Due to (or as a	consequen	ce or):							
20	tificate ig phys as the	ledical		d									
O. DOX	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome o 1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown	2 ☐ Fetal de	eath 3 🗆	Ectopic pregnan Other ( <i>specify</i> )	cy		23	3d. Date of delive Month	ery Day Year	
χ. T	ires that signed by t be deta	þ	Part II. Other significant conditions	s contributing to death but	t not resultin	ng in the und	derlying cause gi	ven in Part I.			_	ne cause of death?	
ecords,	w requ	leted							24a. Was	_		psy findings available	
אוומו עב	n: The lar ficate has r, page 2	Completed							auto perfo 1 ☐ Yes	osy ormed? 2 [XNo	prior to co death? 1 ☐ Yes	mpletion of cause of	
>	ysicia is certi directo	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 ☐ Inpatien	nt 2∏FR	/Outpatient	3 □ DOA Ot	hov.	ath <i>(Check only c</i> Home 5 ☐ Resi		Other (Specif	iv)	
	nding Ph uth. r: After th e funeral	ation: T	27. Manner of Death 1 Manural 5 ☐ Pending 2 ☐ Accident investigat	28a. Date of Injury (Month, Day,	y 28	b. Time of Injury	28c. Inju		28d. Describe			<i>y</i>	
	al or Atters after desal Directo	Certification:	3 ☐ Suicide 6 ☐ Could not determine		ry - At home (Specify)	, farm, stree	et, factory, office		28f. Location ( City or To	Street and wn, State)	Number or Rura	I Route Number,	
	ne Hospit n 24 hour ne Funer	edical	29a. Certifier Certifying (Check only 2 Medical Ex	Physician: To the best of caminer: On the basis of and manner state	examination	dge, death and/or inve	occurred at the estigation, in my	time, date and place opinion, death occ	e, and due to the urred at the time,	cause(s) a date and p	and manner as s place, and due to	stated. the cause(s)	
	Vithi To th	M	29b. Signature and title of certifier	10 -	,			se number			signed (Month,	Day, Year)	
	6		1 / sugal	1 Solf				52242 MD		12/2	6/2008		
			30. Name and address of person what Joseph Barth M					O Prince	Fredric	k MT	20678		
	Sta Registra		31. Date filed (Month, Day, Year)	3 Registrar	r's Signature	A Second	(E)	O ITTIICE	TEGLIC	re til	20070		

DHMH 17 Rev 1/2001

Registrar

DEC

29

2008

Baltimore, Maryland 21215-0036

Box 68760,

P.O.

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Moses Landman 2008 9:53 P December /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Holy Cross Hospital

5. Social Security Number 6. Sex Silver Spring Montgomery 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 X M 2 □ F Director 91 579-01-5557 Jan 12, 1917 Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at 1 ☐ Yes 2 X No Director Silver Spring | 10f. Zip Code Maryland Prince George's 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or in marked other than "natural", or items 23a or in marked other traumatic event, the Medical Evantinar must be any Injury or other traumatic event, the Medical Evantinar must be any once. 3152 Gracefield Rd, #105 20904 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 反 No 2 Specify: 3 ☐ Widowed 4 ☐ Divorced WWII White Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electrician Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Max Landman Frances Unobtainable 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth Landman/Wife 3152 Gracefield Rd, #105, Silver Spring, MD 20904 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Judean Memorial Grnds Dec 29, 2008 Olney, MD 21. Signature of Fameran Sep 22. Name and Address of Facility Hines-Rinaldi Funeral Home 11800 New Hampshire Ave, Silver SPring, MD 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Cardiac Arrest /Medical Due to (or as a consequence of): Examiner Peripheral VAscular Disease Sequentially list conditions, it cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of Physician; The law requires that the death certificate be executed burial-trai Due to (or as a consequence of): physician s the burial P.O. Box 68760. Physician/Medical attending phase as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>≨</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 1 □ Yes 2X No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation To the Hospital or Attendin within 24 hours after death.
To the Funeral Director: Aft completely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

Records, Division of Vital

31. Date filed (Month, Day, Year) State DEC 2 9 2008 Registrar

29b. Signature and title of certifier?

Andrew Kundrat, MD

3110 Gracefield Rd, Silver SPring, MD 20904 2. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D0036716

29d. Date signed (Month, Day, Year)

December 27, 2008

riodde Type o'r Frint i'r black indenbie ink. Ensure Al	ii oopies Ale Legible.	
State of Maryland / Department of Health and N	Mental Hygiene	
Amended item Registrar #20b, perF. Home, 12/29/08, BA Certificate of Death WCHI	Reg. No 2008	43
1. Decedent's Name (First, Middle, Last)	2. Date of Death	3. Time
Physician	Month Day Year	

/Medic Examir

**Funeral** Director

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it a Product Examination in the notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlat-transit

Division of Vital Records, P.O. Box 68760,

ed	it	1 State Registrar #20b,	perF.H	lome, 12/2	9/08,	BA Ce	rtificate of	Death WCH	D	Reg. No.	2008	43	145
sicia	an	1. Decedent's Name (First		*					2. Date of De Month	Day	Year	3. Time o	
edic		Winfield C.							12	23	2008	3:05	Р м
min	er	4a. Facility Name (If not in	_	e street and numb	er)			or Location of Death			County of Death		
		19 East Wir					Berlin		T		orcester		
rai tor		5. Social Security Number 215–38–6943	1)	ex 7. ☑M 2□ F	Age (In yrs.	last birthday) Yrs.	Months Days		8. Date of Bit (Month, Di	1940	Cou	place (State ntry) ngton	
64		Usual Residence of Deced	County		10c C	ity, Town or Lo	cation					0d. Inside (	ity Limite
10	'n					•	cation						s 2 🖾 No
all so	Director	MD WC	orcest	er	t	Berlin	1404 75-0-4-			10 0'''			
DELINE DE L'ORINE		19 East Wir	nd Dr				10f. Zip Code 21811			_	zen of What Cour JSA	itry?	
	Funeral	11. Marital Status	10 011	12. Was Decede	nt Ever in U	l.S. 13.		Decedent of Hispanic Origin? (Specify Yes or No- s, specify Cuban, Mexican, Puerto Rican, etc.)			4. Race - Americ	an Indian.	
9		1 Never Married 2	Married     Married	Armed Force 1 ☐ Yes 2					Rican, etc.)		Black, White,		
1	d b	3 ☐ Widowed 4 ☐ D	ivorced	If Yes, Give Year or Date	s:		1⊡Yes 2X∏No	Specify:			Specify: Wh	ite	
	Completed	15. Do (Specify only	ecedent's Ed	ucation de completed)		16a. Dece	dent's Usual Occu kind of work done	pation during most of worked)	ina	16b. Kin	nd of Business/In	dustry	
	m d	Elementary/Secondary (	(0-12)	College (1-4	or 5+)					C.	ooot Mot	<u>. 1</u>	
H, M						Jilee	t Metal	Specialis		1	neet Met	<u>م ا</u>	
2	9 Be	17. Father's Name (First, Middle, Last)  Winfield C. Langer, Sr.  18. Mother's Name (First, Middle, Maiden Surname)											
	၉	WINTTEIG C. Langer, Sr.  19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)											
		Rita M. Lar						Dr., Ber				0000	
		20a. Method of Disposition	n		20b.		sition (Name of natory or other pla		Date		cation - City or To	wn, State	
5		1 ☐ Burial 2 🛣 Cren 4 ☐ Donation 5 ☐ O						em. 12/2	7/08	Fran	nkford,	DE	
once.		21. Signature of Funeral S	Service Licen	see /	1			ess of Facility Bu					
§ 8		- WM	11/	acid se	20/			iam St.,					
		23a. Part 1. Enter the dise shock, or heart failur	ease, or comp re. List only o	olications that caus	sed the deat	th. Do not ent	er the mode of dyi	ng, such as cardiac	or respiratory a	rrest,		Approxima Interval Be	te tween
an		Immediate Cause (Final disease or condition resulting in death)  a. Metastatic Lung Concer											
cal ner		resulting in death)  a. Due to (or as a consequence of):											
	<u>.</u>	Sequentially list conditions	Sequentially list conditions.										
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events		Due to for	as a consequ	ruence of):							
	xar	that initiated events resulting in death) Last		c Due to (or	as a consec	juence of):							
			·	.d		,					ľ		
	Medical			,u									
		IF FEMALE: 23b. Was decedent pregna	ant	23c. If yes, outcor						2	3d. Date of delive	rv	
	sicia	in the past 12 months 1 ☐ Yes 2 ☐ No	s?	1 Live birt	t at time of		] Ectopic pregnand ] Other (s <i>pecify)</i> _	cy 			Month		Year
	J.	9 🗆 Unknown		9 Unknow									
3	Completed by Physician	Part II. Other significant of	conditions co	ontributing to deatl	but not res	ulting in the u	nderlying cause giv	ven in Part I.			e contribute to the	4.	
	ted			·					10,	Yes 2□	]No 3∏ Prob	ably 4	Unknown
	nple								24a. Was		24b. Were auto	osy findings	available cause of
									perfo 1 □ Yes	rmed?	death?	2 □ No	
	Be	25. Was case referred to n examiner?	- ⊢	Hospital:			100	26. Place of Deat					
	£	1 Yes 2 No 27. Manner of Death		1 ☐ Inp		ER/Outpatier 28b. Time of		4 LI Nursing He			Other (Specify	')	
	ţi	1 Natural 5	Pending investigation	(Month,	Day, Year)	Injury	Wor	k? lYes 2 □No	28d. Describe I	now injury	occurred		
	lfica	3 ☐ Suicide 6 ☐	Could not be determined		Injury - At h	l ome, farm, str	eet, factory, office		28f. Location (	Street and	Number or Rura	Route Nun	nber.
	Sert	4 ☐ Homicide	23.0	building,	etc. (Specia	(y)	•		City or Tov	vn, State)			
	g	29a. Certifier 12 (Check only 2 M	ertifying Phy	/sician: To the be	st of my kno	wledge, deatl	occurred at the ti	ime, date and place,	and due to the	cause(s)	and manner as s	ated.	
	Medical Certification: To	)	Λ	and manner	s or examina stated.	ation and/or in	vestigation, in my o	opinion, death occur	red at the time,	date and p	place, and due to	the cause(	s)
	≥	29b. Signature and title of	certifier	7	.1	1	29c. Licens	se number		29d. Date	signed (Month, I	Day, Year)	
		(1844))()	Nun	Decami	ell	M	D64	645		121	26/08		
,	4	30. Name and address of	person who c	ompleted cause of	f death (Iter	n 23a) (Type,	Print)	0= 0		1	, 1		
( )		31. Date filed (Month, Day,	1M S	eganuel	strar's Signa	(Cas	en to2015	e 10 00	$\times 1733$	70	Isdury	MO	
Stat	(2)	Daily mod (Mornin, Day,	, rour,	11 32. negi	onano olyfic	au i e	*				(		

DHMH 17 Rev 1/2001

Registrar

DEC 2 9 2008

BA 10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM# 20b, c. per FH, G889, 3/11/09, WS

State of Maryland / Department of Health and Mental Hygiene for State Registrar 43146 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death r 23 , 2008 **Physician** Cliffus 5:15 P M В. McKinney December /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner If Under 1 dea 1 Under 2 Arts. 8. Date of Birth (Month, Day, Year) Washington Social Security Number on Hospital Montgomery

9. Birthplace (State or Foreign Adventist **Funeral** Months 1 □ M 2 🗓 F Director 577-30-0629 24,1911 July South Carolin Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits show 7 is marked other than "natural" or items 23a or 28a-f shov traumatic event, the Medical Examinar must be nothing a Director 1 Yes 2 No Maryland Prince George's College Park 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 9217 Limestone Place 20740 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify þ Specify: Black 3√Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) nd Mental Hygiene. marked other than College (1-4or 5+) Domestic Engineer Housekeeping 9th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and 2 should be fill ealth and Mental H n 27 is marked oth Be 2 Randall Brown Patsy Mitchell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 a Department of Health a Important: If Item 27 is any injury or other trau once. LaQuatia N. Josey(Grand-daughter) 9217 Limestone Pl. College Park, Md. 3altimore, 20c. Location - City or 12 0, 5 at 0 20a. Method of Disposition 20b. Place of Disposition (Name of Date MD. National of Memoral Park Washington Nat. Cer ₩Surial 2 Cremation 3 Removal from State Laurel Cem. Jan. 7, 2009 Suitland, 4 Donation 5 Other (Specify) Md. 22. Name and Address of Facility Marshall's Funeral Home, 21. Signature of Funera 4217 9th Street, N.W. Wash. D.C. 20011 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Atherosclerotic Coronary Artery Disease disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) be executed burial-transit and Due to (or as a consequence of): Box 68760 attending physician Physician/Medical the requires that the death certificate as IF FEMALE for use a 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) P.O. the detached 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ≥ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 ▼No has autopsy The certificate 2 **№** No 1 □ Yes Hospital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: Other: 4 \sum Nursing Home 5 \sum Residence 6 \subseteq Other (Specify) XXYes 2 □ No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death Affer t 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 14 Natural death. 2 Accident 1 ☐ Yes 2 ☐ No 24 hours after death Funeral Director: filled in by the 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide XXCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 52326 December 24, 2008

Registrar
DHMH 17 Rev 1/2001

State

7600 Carroll Avenue Takoma Park, Maryland 20912

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

32. Registrar's Sign

James Lightfoot,

31. Date filed (Month, Day, Year)

DEC 3 0 2008

		For State OT IVI State Registrar	aryianu / L	Department of H <i>Certificate of L</i>		Re	<sub>в. N.</sub> 2008	43147
Physici	an	Decedent's Name (First, Middle, Last)				<ol><li>Date of Death Month</li></ol>	ı Day Year	3. Time of Death
/Medic	cal	Freddie Carlton  4a. Facility Name (If not institution, give street and number)	Mowell_	Ale City Town or	Location of Death	Decem b	4c. County of Dea	
Examir	ier	Washington County	Hospi	tal Hage	If Under 24 Hrs.	8. Date of Birth	Wast	The You
Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 7. M 213-92-6208	ge (In yrs. last bir 65	Yrs. Months Days	Hours Min.	July 31	Year) C	ountry)
aryland show	7	10a. State 10b. County	10c. City, Town	n or Location				10d. Inside City Limits 1 □Yes 2 ☑ No
the Ma 28a-f	Director	Maryland Washington  10e. Street and Number	H	Hagerstown		10	g. Citizen of What C	
with with 3a or		11939 Greencastle Pike		21740	r		United S	
death	Funeral	11. Marital Status 12. Was Decedent Armed Forces?		13. Was Decedent of Hi If Yes, specify Cuba		ecify Yes or No-	14. Race - Am Black, Whi	erican Indian,
13-UU-30 n 72 hours after death with the Maryland "natural", or items 23a or 28a-f show edical Examinat must be notified at	þ	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates:		1 □Yes 2 ⊠ No	Specify:	ticari, etc.,	Specify: W	
O 5 2 2	Completed	15. Decedent's Education (Specify only highest grade completed)	16a	Decedent's Usual Occupa (Give kind of work done of life, DO NOT use retired)	luring most of workii	ng   1	6b. Kind of Business	/Industry
within liene.	omp	Elementary/Secondary (0-12) College (1-4ors	5+)	Truck Driv			Truckin	σ
e filed al Hyg other	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle, M		ъ
Marylan d 2 should be tth and Mental 7 Is marked c	To I	Dedrick William Mowell				Watson		
VIAI 12 sh th and 7 is m traum		19a. Informant's Name/Relationship (Type. Print)		b. Mailing Address (Street a				
ten 2		Freddie C. Mowell, Jr. /	20b. Place of	2 S. Mulberry of Disposition (Name of	, D		Own, Mary Oc. Location - City of	
allimore, rmit. Pages 1 ar spartment of Her portant: If Item y Injury or othe		1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		ery, crematory`or other place rick Cremator	Decei		rederick,	Maryland
partimore, indryland 212 permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event, If any once.		21. Signature of Funeral Service Licensee		22. Name and Addres			ineral Hom	es, P.A.
0 89E 8 8		122						ryland 21702
Physician /Medical		23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each li Immediate Cause (Final disease or condition resulting in death)	of the death. Do ine.	Shock	g, such as cardiac c	r respiratory arre	st,	Approximate Interval Between Onset and Death
Examiner	ē	Sequentially list conditions, if any, leading to immediate Due to (or as	a consequence	of):				
cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter uncertainty Cause (Disease or Injury that initiated events						
ficate be executed thy sician and the burial-transit	al Ex	resulting in death) Last  Due to (or as	a consequence	of):				
tificat rug phy as the	fedical							
the death certificate be executed the death certificate be executed the attending physician and ched for use as the burial-transit	Physician/M		e of pregnancy 2 ☐ Fetal death at time of death	h 3 Ectopic pregnancy 5 Other (specify)	1		23d. Date of de Month	elivery Day Year
res that signed by be deta	Ş	Part II. Other significant conditions contributing to death t	1	in the underlying cause give	en in Part I.			o the cause of death?
requii	eted	- Multiplo Mye	ima			1 Tes	0 -	robably 4 Unknown
VII.dal NECOTOS, slcian: The law requires t certificate has been signe rector, page 2 should be c	Completed				10	24a. Was an autopsy perform 1 □Yes 2	prior to	
VII,	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 No Hospital: 1 npati	iont 2 🗆 EB/O	utpatient 3 □ DOA Othe	26. Place of Death			
g Phy g Phy ter this neral d		27. Manner of Death 28a. Date of Inj.	ury 28b.	Time of lnjury 28c. Injury Work		28d. Describe how	nce 6 □ Other (Spewinjury occurred	ecity)
endin eath. or: Aff	atio	2 Accident investigation	ly, rear)		Yes 2 □ No			
LIVISION  Jordan  Jord	Certification: T	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of In building, e	jury - At home, fa tc. <i>(Specify)</i>	arm, street, factory, office	1	28f. Location (Stro City or Town,	eet and Number or F State)	ural Route Number,
To the Hospital or Attending Physician: The law requires that the dwithin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.	Medical C	29a. Certifier (Check only one)  Certifying Physician: To the best 2 Medical Examiner: On the basis and manner st	of examination ar					
To tl withi To tl	M	29b. Signature and title of certifier	W-1	29c. License D 6			d. Date signed (Mon	
10		30. Name and address of person who completed cause of	death (Item 23a)	(Type, Print)	Live /	\ _ i	}	27, 2008 n, MO <sup>2174</sup>
Sta	te	Pajman Danai M.D.  31. Date viled (Month, Day, Year)  32. Regist	12 8 mr's Signature	& Sperke	Hill /	ive , t	1990 21 on	4, 140
Registr		DEC 2 3 2008 > A	Colum 1	A. Coores				

n	Registrar  1. Decedent's Nam					Ce	rtificate of	Death	2. Date of Dea Month		2008	3. Time of Death
al .		Alfor		Malc			T	- I ti of Danti	Dec	_		6:20 A M
er	4a. Facility Name (	Regiona	al H	ospita	1		Laure			4c. County of Death Prince George		
	5. Social Security N 578 04 3	030	6. Sex	M 2□F	7. Age (In yrs. 83	last birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day Apr 28	, Year) 1925	PO.	nplace (State or Foreign Land
1	Usual Residence o 10a. State	10b. County			10c. Ci	ty, Town or Lo	ocation					10d. Inside City Limits
Director	MD		vard	L	Co	olumbia				1  Yes		
ä	10e. Street and Nu 6862 Car		רווכ				10f. Zip Code 21044		10g. Citizen of What Country?  United States		-	
by Funeral	11. Marital Status  1 Never Marr	ried 2 <b>1</b> Marr	ried	12. Was Decedent Ever in U.S. Armed Forces? 1			 Was Decedent of I If Yes, specify Cub 1 □ Yes 2X No	Hispanic Origin? (Spoan, Mexican, Puerto	pecify Yes or No- pecify Rican, etc.)	14. Ri Bl	lack, White,	ican Indian, , etc. hite
		15. Deceden	ıt's Edu	cation	103.	16a. Dece	dent's Usual Occu	pation	kina	16b. Kind of		
Completed	Elementary/Seco		Si gradi	College (1-	4or 5+)	(Give kind of work done during most of working life. DO NOT use retired)  Electrical Engineer					rcial	Constructi
Be	17. Father's Name (First, Middle, Last) Alfred Malcher					18. Mother's Name (First, Middle, Maiden Surname) Olga Gutwinska						
2	19a. Informant's N						2b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co 1862 Caravan Court Columbia, MD 21044					ïp Code)
		sposition Cremation 5 □ Other (S		temoval from S	state i		osition (Name of matory or other pla Crematory		Date 27-2008	20c. Location		
	21. Signature of F			in Al	M0104	44 2	2. Name and Addr	ess of Facility Har	ry H. W	itzke':	s Fam	ily FH Inc
	Coguentially list as		1	_	or as a consec	onia quence of):						
ical Examiner	Sequentially list or if any, leading to in cause. Enter Undo Cause (Disease or that initiated event resulting in death)	onditions, nmediate erlying r injury		Seps Due to (	or as a consec	quence of): quence of): xicity						
_	that initiated event	onditions, nmediate erlying r injury s Last  t pregnant 2 months?		Due to (comma Due to (compa Du	is or as a consect din To or as a consect or as a consect or as a consect come of pregnirth 2   Fets ant at time of	quence of):  quence of):  xicity quence of):  ancy al death 3	□ Ectopic pregnan	ісу			Date of delin	very Day Year
by Physician/Medical	IF FEMALE: 23b. Was deceder in the past 12 1	onditions, nmediate ertying i rinjury s Last  ht pregnant monts?	ons co	Due to (comma Du	is or as a consect din To or as a consect or a	quence of):  XICITY quence of):  ancy al death 3   death 5	Other (specify)			obacco use co	Month	Day Year the cause of death?
by Physician/Medical	IF FEMALE: 23b. Was deceder in the past 12 1	onditions, mmediate errlying in rinjury is: Last that pregnant 2 months?	ons co	Due to (comma Du	is or as a consect din To or as a consect or a	quence of):  XICITY quence of):  ancy al death 3   death 5	Other (specify)		1 □ Y  24a. Was a autop: perfor	obacco use co res 25 No an sy rmed?	Month  ontribute to  3 □ Pro	the cause of death?  bably 4 Unknown  topsy findings available completion of cause of
Be Completed by Physician/Medical	IF FEMALE: 23b. Was deceder in the past 12 1	onditions, namediate errying in rinjury is Last interpregnant 2 months?	ons col	Due to (comma Du	is or as a consect din To. or as a consect come of pregn irth 2 Feta ant at time of own	quence of):  quence of):  xicity quence of):  ancy al death 3   death 5   sulting in the u	Other (specify)	26. Place of Dea	1 □ Y  24a. Was a autop: perfor 1 □ Yes  th (Check only or	obacco use co 'es 2X No an 24t sy med? 2 X No	ontribute to  3  Pro  b. Were aut prior to codeath? 1  Yes	the cause of death?  babably 4 □ Unknown  topsy findings available  completion of cause of
To Be Completed by Physician/Medical	IF FEMALE: 23b. Was deceder in the past 12 1   Yes 2   25. Was case refe examiner? 1   Yes 2   27. Manner of Dea 1   27. Manner of Dea 1   28. Case as a case refe examiner?	onditions, mediate eritying striping st	ons col	Due to (comma Du	or as a consection of as a consection of as a consection of pregneral and at time of own.	quence of):  quence of):  xicity quence of):  ancy al death 3   death 5   sulting in the u	Other (specify) Inderlying cause gi  nt 3 □ DOA Other (specify)	26. Place of Dea	1 □ Y  24a. Was a autop perfor 1 □ Yes	obacco use co res 2X No res	Month  ontribute to  3  Pro  b. Were aut prior to codeath? 1 Yes  Other (Spec	the cause of death?  babably 4 □ Unknown  topsy findings available  completion of cause of
To Be Completed by Physician/Medical	IF FEMALE: 23b. Was deceder in the past 12 1  Yes 2 9 Unknown  25. Was case refe examiner? 1 Yes 2 5 27. Manner of Dea	onditions, namediate erlying rinjury is Last  Int pregnant 2 months?  No namediate erlying rinjury is Last  Int pregnant 2 months?  No namediate rindury is Last	ons concer	Due to (command)  Seps Due to (command)  Due to (command)  Courned  Courned	or as a consection as a consection or as a consection of pregnant at time of the consection of the	quence of):  quence of):  xicity quence of):  ancy al death 3   death 5    sulting in the u  BER/Outpatie  28b. Time of Injury  loome, farm, st	Other (specify) Inderlying cause gi  nt 3 □ DOA Other (specify)	26. Place of Dea her: 4□ Nursing H  ury at ork? □Yes 2□No	1  Y  24a. Was a autop. perfor 1 Yes  th (Check only or ome 5  Resid 28d. Describe h	obacco use co	Month  ontribute to  3 □ Pro  b. Were aut prior to co death? 1 □ Yes  Other (Spec	the cause of death?  babably 4 □ Unknown  topsy findings available  completion of cause of
Certification: To Be Completed by Physician/Medical	Cause (Disease of that initiated event resulting in death)  IF FEMALE: 23b. Was deceder in the past 12 1 □ Yes 2 9 □ Unknown  Part II. Other signi  decubi  25. Was case refe examiner? 1 □ Yes 2 27. Manner of Dea 1 ▼ Natural 2 □ Accident 3 □ Suicide	onditions, namediate erlying rinjury is Last  Int pregnant 2 months?  No namediate erlying rinjury is Last  Treed to medica and the condition of the condition investing the condition of the condition of the condition investing the condition of	ons concer	Due to (couma) Due to	or as a consection as a consec	quence of):  quence of):  xicity quence of):  ancy al death 3   death 5   sulting in the unit of the content of	other (specify) Inderlying cause gi  Int 3 DOA Other (specify) Int 3	26. Place of Dea her: 4□ Nursing H  ury at ork? □Yes 2□No	24a. Was a autop. perfor 1   Yes th (Check only or ome 5   Resid 28d. Describe h	obacco use co	Month  ontribute to  3  Pro  b. Were aut prior to or death? 1  Yes  Other (Specurred	the cause of death?  the cause of death?  babably 4 \subseteq Unknown  topsy findings available  completion of cause of  2 \subseteq No  cify)  ral Route Number,
To Be Completed by Physician/Medical	IF FEMALE: 23b. Was deceder in the past 12 1 Yes 2 9 Unknown Part II. Other signing decubing the examiner? 1 Yes 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	onditions, mediate eritying string rinjury s Last  Int pregnant months?  It	ons consecutive for the second security of the second seco	Due to (couma Du	or as a consection of as a consection of as a consection of pregnant at time of common of the common	auence of):  quence of):  xicity quence of):  ancy al death 3   death 5   sulting in the unit of the content of	other (specify)  Inderlying cause given the convertigation, in my  Other (specify)  Other (	26. Place of Dea her: 4 □ Nursing H Jry at ork? □Yes 2 □ No	24a. Was a autop. perfor 1   Yes th (Check only or ome 5   Resid 28d. Describe h 28f. Location (S City or Tow or of at the time, of the control of the contr	obacco use co	b. Were aut prior to c death? 1 Yes  Other (Specurred	the cause of death?  the cause of death?  babably 4 □ Unknown  topsy findings available  completion of cause of  2 □ No  cify)  ral Route Number,  e stated.  to the cause(s)  n, Day, Year)

**Physician** /Medical Examiner

Baltimore, Maryland 21215-0036

Box 68760,

P.O.

of Vital Records.

Division

Hospital or Attending Physician: The law requires that the death certificate be

Completed by

Be

Certification: To

Medical

23e. Did tobacco use contribute to the cause of death?

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. Parkinson's Disease

28a. Date of Injury (Month, Day, Year)

1 ☐ Yes 2 ☐ No 3 ☐ Probably 42 ☐ Unknown 24a. Was an

24b. Were autopsy findings available prior to completion of cause of death?

autopsy performed? 1 ☐Yes 2 ☐No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

2 No

1 Yes 2 XNo 27. Manner of Death 1XXNatural 2 Accident

3 Suicide

29a. Certifier

25. Was case referred to medical examiner?

5 ☐ Pending investigation 6 ☐ Could not be determined 4 Homicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of

28d. Describe how injury occurred Injury at Work? 1 ☐Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one) 29b. Signature and title of certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number

and manner stated.

D65312

December 23, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

Suda'lihan Siva MD 8600 Old Georgetown Rd. Bethesda, MD 20814

State Registrar

31. Date filed (Month, Day, Year) DEC 2 9 2008



ours after death. neral Director: A filled in by the fu death.

To the Hospital within 24 hours a To the Funeral I

Physician /Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be execute within 24 hours aft To the Funeral Di completely filled in

Physician

/Medical

Examiner

**Funeral** 

Director

r 28a-f show notified at

must be n

'natural", or items dical Examiner ma

permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiene Important: If item 27 Is marked other that any Injury or other traumatic event, the once.

Director

Funeral

þ

Completed

Be (

with the Maryland

death

Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

ical Examiner	Sequentially list conditions, if any, bearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	dvanze	Deenent	ia							
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown  23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown											
Completed by Ph	Part II. Other significant conditions of GENH)  N IDD		sulting in the underlyin	g cause given in Part I.	23e. Did tobacci 1 ☐ Yes	2 No 3 □ P	o the cause of death?					
Compl	COP	? I death?	b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No									
Be	25. Was case referred to medical examiner?											
2	1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ecify)									
	27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation		28b. Time of Injury M	Home 5 ☐ Residence 6 ☐ Other (Specify)  28d. Describe how injury occurred								
Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	and Number or R ate)	lural Route Number,									
29a. Certifier  (Check only one)  29a. Certifier  (Check only one)  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month. Day, Year												
Me	29b. Signature and title of certifier  SHAHNAWA	29c. License number 29d. Date signed (Month) 29c. License number 29d. Date signed (Month) 12 - 3 (					th, Day, Year)					

DHMH 17 Rev 1/2001

State Registrar 105, ELKTON, MD21921

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

HIGH

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 2 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month **Physician** 11:35P<sup>™</sup> Ruth G. McGarry December29,2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Lorien Mt. Airy Nursing Home Mt. Airy Carroll If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Days Hours 202-14-7953 Pennsylvania Director Nov. 29, 1912 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Evaninar must be notified at 1 ☐Yes 2 X No Director Maryland Carroll Mt. Airy 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 201 Waterville Road, Apt. 25 21771 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🎾 No Specify. þ Specify: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 12 should be filed within 7 th and Mental Hygiene. 7 is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) Food Industry 12 Clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alexander Thom Eunice Barnard ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health an Important: If item 27 is r any injury or other traur Forest McGarry/Son 131130rleans Street, Lake Ridge, Virginia 22192 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Joseph Cemetery 1-3-09 NewBrighton, PA. 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. 21. Signature of Funeral Service Licenses Marzullo 6009Harford Road, Baltimore, Maryland21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** SICK SINIS SYNDROME 45ARS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 4 Frans ISCHEMIC if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine requires that the death certificate be executed burial-transi and Due to (or as a consequence of): Box 68760, physician Physician/Medical use as the attending p IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 

Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death Year Month 5 Other (specify) P.O. the detached 9 Unknown 9 Unknown as been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Dampat 14 1 ☐ Yes 2 ☐ Who 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has , page 2 autopsy performed?

1 Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Aursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident filled in by the 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 29a. Certifier 1 🖟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and July MD 026499 12-30-08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) E. MILLER, MT. AIRS. MD 21771 GULNELL DR. 31. Date filed (Month, Day, Year) 2009 32 Registrar's Signature State Registrar

A.

			Type or Print State of Mar					-	_	
	•	For State Registrar		,		tificate of		,	Reg. No. 200	8 43152
		Decedent's Name (First, Middle, Last	st)					2. Date of De	eath	3. Time of Death
Physicia /Medica		Frank C.	Olivey					Dec.	22 2008	
Examine		4a. Facility Name (If not institution, giv				4b. City, Town, o	r Location of Deat	h	4c. County of D	Peath
		Kline Hospice H	ouse				Airy			lerick
Funeral		5. Social Security Number 6. S	Sex 7. Age SatM 2 ☐ F	(In yrs. last		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month, D	ay, Year)	Birthplace (State or Foreign Country)
Director		219-48-9350 Supplies the Land Service of December 1	Q <sub>1</sub> 2	61	Yrs.			April :	12,1947   N	ew York
and	- 1	10a. State 10b. County		10c. City, T	own or Lo	cation				10d. Inside City Limits
Mary -f sho	호	Maryland Freder	ick		Frad	erick				1⊠Yes 2□No
with the Maryland a or 28a-f show	Director	10e. Street and Number	ICK		rrcu	10f. Zip Code			10g. Citizen of What	t Country?
after death with the Maryland or items 23a or 28a-f show priner must be a withed at		811 Motter Aven	116				21701		Unite	ed States
death	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S.	13. V	Vas Decedent of h	dispanic Origin? (S an, Mexican, Puerl	specify Yes or No		American Indian, /hite, etc.
after or ite	by Fu	1 ☐ Never Married 2 🔀 Married	1 TxYes 2 □ No		1	☐Yes 2☑No	Specify:	or mounty overly	Specify:	White
ural",	d b	3 Widowed 4 Divorced	Year or Dates: V							
"nat	ete	15. Decedent's Ed (Specify only highest gra	ducation a <i>d</i> e co <i>mpleted)</i>	1	(Give	lent's Usual Occup kind of work done OO NOT use retire	during most of wor	rking	16b. Kind of Busine	ess/Industry
withir ene. than	Ĕ	Elementary/Secondary (0-12)	College (1-4or 5+)	)		es Clerk	u)		Auto Par	t.c
filed within 72 hours Hygiene. other than "natural", ent, Irc Medical Exa	Be Completed	17. Father's Name (First, Middle, Last,	)		Jar	es Cleik	18. Mother's Nar	ne (First, Middle	e, Maiden Surname)	. L 5
d be ental ked c	9 9	Herbert Olivey					Betty	Nagle		
shoul ind M ind M i mar	-	19a. Informant's Name/Relationship (	Type. Print)		19b. Mailin	g Address (Street			per, City or Town, Sta	te, Zip Code)
alth a		Judith Olivey /	Wife		811	Motter A	Avenue F	rederic	k, Marylar	nd 21701
item item		20a. Method of Disposition		20b. Plac		sition (Name of natory or other pla		Date	20c. Location - City	
Page nent on int: If		1 ☐ Burial 2 🖾 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif				Cremator	Deci	ember 2008	Frederic	k, Maryland
permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any Injury or other traumatic event, I'm Medical Exa once.		21. Signature of Funeral Service Licer	nsee						Funeral Ho	
89 11 18		12291	t		16	21 Oposs	umtown P	ike Fre	ederick, M	aryland 21702
		23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that caused to one cause on each line	he death. I	Do not ent	er the mode of dyi	ng, such as cardia	c or respiratory a	arrest,	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	a "	Asust	ole					Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a	consequen	nce of):					,
	_	Sequentially list conditions,	b	Uren	na					days
sit sed	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequen	nce of):	A				1000
be executed sian and urial-transit	xan	that initiated events resulting in death) Last	c Due to (or as a	consequen	dvati	on				anys
be e sician buria	_		S.			Lucking	& perfora	1		months
ficate phys the	Physician/Medica		d	Dowe	· VOS	Truction_	a perfora	111.64		
n certi	Ž	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of						23d. Date of	delivery
death e atte d for i	cia	in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at t			] Ectopic pregnand ] Other <i>(sp</i> ec <i>ify)</i> _	су		Month	Day Year
t the by th	hys	9 Unknown	9 Unknown							
ss tha gned	P P	Part II. Other significant conditions	1 1 1			nderlying cause giv	en in Part I.	23e. Did	tobacco use contribu	te to the cause of death?
aquire en si	ed	meta	static colon	N COV	ncer			1 🗆	Yes 2☑No 3□	Probably 4 Unknown
law re as be 2 sho	Completed							24a. Was	s an 24b. Wer	e autopsy findings available r to completion of cause of
The ate h page	E O							perf	ormed?   deat	th? Yes 2 10
sician: The law certificate has t irector, page 2 s	Be	25. Was case referred to medical examiner?					26. Place of Dea			
hysion this call dire		1 Yes 2 No				I 3 DOA			idence 6 Other	Specify)
After unera	.: 0	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day,	Year) 28	3b. Time of Injury	Wor	rŔ?	28d. Describe	how injury occurred	
ttend death tor: /	cat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not b		n. Albani			]Yes 2□No	OOf Location	(0)	- Devel Best Months
or Al after of Direction by	Certification: To	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)								
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the buring the purification.	Medical C		nysician: To the best of miner: On the basis of e and manner state	examinatio						
o the orther of the omple	Mec	29b. Signature and title of certifier	7			29c. Licens	se number	T	29d. Date signed (N	fonth, Day, Year)
-s+o		•	The	MI	D	D	DØ 6744	2	12/2	2/2008
1181		30. Name and address of person who	completed cause of dea	ath (Item 23	3a) (Type,					•
1 ver			Yun Oh				nson Driv	e Fred	erick, MD	21702

State Registrar 31. Date filed (Month, Day, Year)

Oh 46-B Thomas Johnson Drive Frederick, MD 21702

32. Registrar's Signature DEC 2 3 2008

Registrar

State

Box 68760.

Division of Vital Records,

32F

MD

Bole

Date filed (Month, Day,

DEC 3 0 2008

outhern Aug SE

08-09583 Mackenzie Ann Ma	arqu		ase Type o	or Print	in Bladyland /	Depart	ment	of Health	sure All Copi and Mental I	<b>ies Ar</b> Hygien	e <b>Legib</b> l e	e. 20	08	4315
	1-	For State				Certif	ficate	of Death			Reg. No	2.0	3. Time of D	
Physician		gistrar Decedent's Name	(First, Middle,Las	t)	12				177	2. Date Mon	of Death th Day ember 21	Year	0330 h	
Medical Examine	er	Macken	zie Ann	Margu	erite	Papo	<u>i</u>	0'1 T-	wn, or Location of Dea			4c. County of Deat	h ·	/
<i>f</i>	4	a. Facility Name (if	not institution, giv ith of Berryma					Owing:	s Mills			Baltimore Co	unty ,	205
Funeral	5	Social Security No	umber 6. S	ex	7. Age	(In yrs. last	birthday	) If Under Months		din.		M/DD/YYYY) 9. B Fore	an	1
Director	5	76-63-04	05	M 2 X	F	15		Yrs.		Ja	n. 10,	1993	ountry)Haw	aii .
	Ū	sual Residence of				I0c. City, T	own or L	ocation					10d. Inside	1
w any						Parkv							1 Yes	2 X No
ykand a-f sho	٩	[aryland] Oe. Street and Nur	Baltimor	e		Palky	1116	10f. Zip	Code		10g. (	Citizen of What Co	untry?	
or 28	Director	9112 Orbi						212	34			5A		
with the ris 23a	la ,	1. Marital Status		12. Was	Decedent led Forces?	er in U.S	. 13	. Was Deceder	nt of Hispanic Origin? / Cuban, Mexican, Pu	( Specify Yerto Rican,	es or No- etc.)	14. Race - Am White, etc.	erican Indian, I	Slack,
death ritem	Funeral	1 X Never Marrie		1 Y	es 2	X No			X No specify:			Specify: Wh	ite	
after ral", o	J.	Widowed  15. Decedent's Ed	4 Divorce			nleted)	160 Dec	edent's Usual (	Occupation (Give kind	of work do	one 16	b. Kind of Busines		
hours	te d	15. Decedent's Ed			ge (1-4 or 5		duri	ng most of wor	king life. DO NOT use	retired)				
36 nin 72 e. than '	흴	9	Sildery (* 12)				stu	dent				student/	educati	on
5-00 Sed with	Completed	17. Father's Name	(First, Middle, La	st)					18.Mother's N					
Baltimore, MD 21215-0036 permit. Pages I and 2 shouldbe filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "matural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be politifed at once.	Be .	Benjamin	Frank Pa	apoi_			1 19h N	Mailing Address	(Street and Number	ine I	Michel Route Numbe	le Brown r, City or Town, St	ate, Zip Code)	-
3 27 should is ma atic er	의	19a. Informant's Na							tan Road,		sville	. Marvla	nd 212	234
md 2 safth a		Benjamin 20a. Method of Dis	sposition				lace of D	Disposition (Nar	me of cemetery,	Date	e 2	0c. Location - City	or Town, Stat	е
Ore ges 1: t of Hi is Hit		1 Burial 2	X Cremation		oval from Sta			or other place	Crematory1	2/23/	2008	Alexandr	ia, Vi	rginia
it. Pa		Donation 5	Other Spec	ensee		met	торо	22. Name and	Address of Facility N	Moles	worth-	William '	Funera.	L Home
Ba perm Depa Imp			m	11/	~			26401	Ridge Road	l, Da	mascus	, Maryla	nd 208	mate Interval
Physician		23a. Part I. Enter t	the disease, or co nly one cause on	mplications each line.	that caused	the death.	Do not e	enter the mode	of dying, such as card	liac or resp	matory arrest	, shock, or nour	Betwee	n Onset and Death
Medical aminer	1	Imme the Cause	(Final disease	a. Multipl	e Injuries	3	r\.		14				1	-
diffine		or condition result		Due to (	or as a cons	equence of	1):							
	ē	Sequentially list of if any, leading to it	immediate	Due to (	or as a cons	equence o	f):							
	Examiner	cause Enter Und (Disease or injury	that initiated	e. Due to (s	or as a cons	sequence o	f):							
ecuted and - transit	Exa	events resulting in	n death) Last	d.			·							
	ical	UNPENDE	D	AMEN	NDED									
Box 68760, e death certificate be ex the attending physician ted for use as the burial	sician/Medic	IF FEMALE:	- 43 - 46		If yes, outco	me of preg	nancy		3 Ectopic p	oregnancy		23d. Date of del Month	ivery Day	Year
687 ertific iding p	ian/	23b. Was deceder past 12 mont	nt pregnant in the hs?	1 _	Live birth Pregnant a	at time of de	eath 5	Fetal death Other (Sp		Jiogridiloy				
Box 68760, e death certificate be the attending physic ed for use as the bur		1 Yes 2			Unknown							acco use contribu	to to the cause	of death?
Records, P.O. Box 68760, The law requires that the death certificate be ex cate has been signed by the attending physician page 2 should be detached for use as the burial.	Phy.	Part II. Other sig	nificant conditio	ns contrib	outing to dea	ath but not	resulting	in the underlyir	ng cause given in Part	i I.		2 V No 3		
, P.O. res that the signed by	d by									- (	24a, Was a	1 24h We	re autopsy fino	lings available
rds requi	ompleted										autops perforr	y pric	r to completion th?	n of cause of
Recol The law icate has	E										1 <b>Y</b> Yes 2	No 1	Yes	2 No
/ital R ysician: T his certific director, p	S S	25. Was case ref	ferred to medical	Linenitei			7		26.Place of Death (C	Nursing H		Residence 6	Other: Scene	
of Vital Records, ng Physician: The law require After this certificate has been si tuneral director, page 2 should b	10 B	1 ✔ Yes	2 No	Hospital	1 Inpa	tient 2		itpatient 3 ime of Injury	DOA Other 4	28	d. Describe h	ow injury occurred		
Ing P	=	27. Manner of De	eath 5 Pendi	F	OUND: Day	y,Year)	FOU	ND:	1 Yes 2	<b>i</b> Dri	iver auto a	uto collision		
IVISION or Attendather death Director:	g‡;	2 🗸 Accident	Inves	igation 2	Dec 21, 200 8e. Place of	08 Injury - At	0314 home, fa	rm, street, facto	ory, office building, etc		T	treet and Number		
Division of N pital or Attending Phy ours after death. eral Director: After t	Certification:	3 Sulcide	deter	not be	Specify) Ir	nterstate	/Expre	ss		79		of Berryman's		s Mills, MD
Division of Vital F To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifi completely filled in by the funeral director,				ysician: To	the best of	my knowle	dge, dea	ath occurred at	the time, date and pla my opinion, death occ	ce, and du	e to the caus ne time, date a	e(s) and manner a and place, and due	s stated. e to the cause(	s)
To the Hos within 24 ho To the Fun completely	Medical	one) 2		and n	ie basis of e nanner state	ed.	and/or ii		29c. License number			29d. Date signed	(Month, Day	Year)
F S F S	Ž	29b. Signature a	and title of certifie	11	00 0	O 4	, .		O.C.M.E.			December 2	1, 2008	
			ude	H	Ell	U OL	m 2301		7			- 12		
3	1	30. Name and a Carol Alla	an. MD Ass	who comple sistant M	eted cause o edical Ex	aminer	111	Penn Stree	t, Baltimore, MD	21201				
	Stat	Od Data Black (I	Month, Day, Year)			trar's Sign	ature		-		boards	1		
Regi		_			1		EC 2	3 2008	Figure 1	D.	AND THE PERSON			

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 23 2008 **Physician** DECEMBER 5:35 P M ROLLINS D. SARAH /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEROGE'S CLINTON SOUTHERN MARYLAND HOSPITAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) MAY 5 1944 6. Sex 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 M 2 XF SOUTH CAROLINA Director 248-74-3598 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural" any intury or other traumatic events any intury or other traumatic events. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1√Yes 2□No Director PRINCE GEROGE'S BRANDYWINE MD10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20613 USA Funeral 13201 A OLD INDIAN HEAD ROAD 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 XNo 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married BLACK 1 ☐ Yes 2 🛛 No Specify Specify: ≥ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE 4+ OFFICE MANAGER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be SARAH ALSTON ABE DENNIS SR. မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 30601 690 FOURTH STREET # 8308 ALTHENS, GEORGIA APRIL GOMES/DAUGHTER 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State RIVERDALE CREMATORY 12/30/2008 RIVERDALE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) J. B. JENKINS FUNERAL HOME 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) SIRA /Medicat Due to (or as a consequence of): Examiner bowe schemic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): attending physician for use as the burial Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Day Month Year 5 ☐ Other (specify) PO sate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificate 25. Washing referred to medical 21 No 2 🖾 No 1 □ Yes Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 \sum Nursing Home Certification: To 1 ☐ Yes 2 🖾 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident the Director: 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral C 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 12/24/08 D64289 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar VARSHA

7503 SURRATTS ROAD CLINTON, MARYLAND

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Physician 04:10 AM John Kamsey 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore University of Maryland Medical Center If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 11/28/1956 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 X M 2 □ F Cheverly, MD 52 219-82-7015 Director Usual Residence of Decedent 10d. Inside City Limits and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 28a-f show ral", or items 23a or 28a-f shov 1X Yes 2 □ No **Funeral Director** Maryland | Prince George's Hyattsville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20875 6300 Baltimore Avenue Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 □ Yes 2 🛣 No Specify: White Baltimore, Maryland 21215-0036 Specify: Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) of Health and Mental Hygiene.
Item 27 Is marked other than "natur other traumatic event, in Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Production Worker Private 7th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frances Virginia Kerns ပ္ John Lewis Ramsey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6300 Baltimore Ave., Hyattsville, MD 20875 Quan Mathis/guardian 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition Pages 1 purmit. Pages 1
D. partment of H
In portant: If ite
any Injury or ot
orce. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Washington Natl. Cem. 12/30/2008 Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Tack WWW Cedar Hill FH 4111 PA Ave., Suitland, MD 20746 Jack A. Wilson, MO1246 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Septic Shoc **Physician** disease or condition resulting in death) /Medical Due o (or as a consequence of) Examiner Enterococcal Backeremia day Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician: The law requires that the death certificate be executed burial-transi Exami Due to (or as a consequence of): P.O. Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 🗌 Ectopic pregnancy Month 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, \$ 15 Infection 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an autopsy perform Acute Kidner 1∐Yes 2⊠No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA ٩ 28c. Injury at Work? Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: 27. Manner of Death Hospital or Attending 24 hours after death. 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only within 2. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1366646697 12-25-2008 30. Name and address erson who completed cause of death (Item 23a) (Type, Print) Baltimore MD Vaugher 31. Date filed (Morith, Day, Year State DEC 3 0 2008

DHMH 17 Rev 1/2001

Registrar

43157

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legibie.

			For State	State	of Maryl	•	artment of F				
		-	1. Decedent's Name (First, Middle	, Last)		0 4	//	Doain	2. Date of Dear	eg. No. th Day Year	3. Time of Death
	Physici: /Medic		Betty 1	Srubb		Ruda	5111		1/2	22 200	8 8:45AM
	Examin	er	4a. Facility Name (If not institution			DMC	4b. City, Town, or FREDE	r Location of Deatl Dエ <b>ベド</b>	n	4c. County of Deal	
Н	Funeral		HOMEWOOD AT  5. Social Security Number	CRUMLAN 6. Sex		XMS yrs. last birthday		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	9. Bin	thplace (State or Foreign
L	Director		577-24-6934	1 □ M 2 🗹 F		37 Yrs.	Months Days	Hours Min.	MAR 10	1921	MD
	ow ow		Usual Residence of Decedent  10a. State 10b. County		100	. City, Town or L	ocation				10d. Inside City Limits
	e-feh	ctor	MD FREI	DERICK		FREDE	CRICK				1 ☑Yes 2 ☐ No
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time 27 is marked other then "natural", or items 23a or 28e-f show eny injury or other traumatic event, the Medical Evantment must be inclified at once.	Funeral Director	10e. Street and Number 7431 WILLOW	ROAD, #	24		10f. Zip Code 2170	2	1	0g. Citizen of What Co USA	ountry?
	death	nera	11. Marital Status	12. Was Dec	edent Eyer	in U.S. 13.	Was Decedent of H	lispanic Origin? (S	pecify Yes or No-	14. Race - Ame Black, Whit	
0036	rs after	by Fu	1 Never Married 2 Marr 3 Widowed 4 Divorced		2 No		1 ☐ Yes 2 ☑ No	Specify:	o 1 (1021), 0(0.)	Specify: W]	
5	2 hours		15. Deceden	s Education		16a. Dece	dent's Usual Occup	ation	,	16b. Kind of Business	/Industry
2	ithin 7	Completed	(Specify only highes Elementary/Secondary (0-12)	College (		lite.	e kind of work done o DO NOT use retired	during most of wor d)	king	DANIZINIC	
2	filed w Hygier ther th	e Col	17. Father's Name (First, Middle,	Last)		BAN	IKER	18. Mother's Nan	ne (First, Middle, I	BANKING	
/land	fental rked o	To Be	HARRY DANIE	,						E PADGET	r
Mary	2 should and N ie mail		19a. Informant's Name/Relations				_			City or Town, State, 2	
e, e	1 and 16alth 16alth 17 27 17 17 17		ETHEL SHANNO  20a. Method of Disposition	ON / SIS		7401 b. Place of Disp		RD., #		EDERICK,  20c. Location - City or	MD 21702
E	ages ant of l nt: if its y or o		1 Burial 2 Cremation 4 Donation 5 Other (S		State	cemetery, cre	matory or other place	I		FREDERI	
galtil	Departine Departme Importan eny injur	ı	21. Signature of Funeral Service				2. Name and Addres	ss of Facility		LKEDEKT	CK, MD
מ	88 = 8		141.4					X 86, B	ARNESVI	LLE, MD	20838
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that only one cause on	caused the deach line.	death. Do not en	ter the mode of dyin				Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a		nsequence of):	Karotis	c. an	diona	cularde	Par
	Examiner		Commence the line of the state of	50000	TOPPES & COT	isaquarica bi).					
	sit ad	iner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	or as a con	sequence of:					
•	be executed icien and burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to	(or as a con	sequence of);					
9/00	cate be executed physicien and the burial-transit	dicai E		d							
		Med	IF FEMALE:								
20 <b>2</b>	w requires that the death certif been signed by the attending should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 wonths?		tcome of pre pirth 2 □ I nant at time	Fetal death 3[	☐Ectopic pregnancy ☐ Other (specify)			23d. Date of del Month	ivery Day Year
į	t the d by the ached	hysi	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□ Unkn		51 40241 51					
, L	es tha igned be det	by P	Part II. Other significant condition	ns contributing to d	eath but not	resulting in the u	inderlying cause give	en in Part I.	23e. Did tob	pacco use contribute to	
0.00	requir	eted	Agree Jen	non /	Type	H U	Lavele	7	1 □ Ye		obably 4 Unknown
) E	he law shest ge 2 s	Completed	In agus	LOSS					24a. Was as autops perforn	y prior to	itopsy findings available completion of cause of
N I Cal	an: Ti	0	25. Was case referred to medical					26 Place of Dea		No 1□Yes	2 No
5	hysici his cer I direc	To B	examiner? 1 ☐ Yes 2 No	Hospital: 1	Inpatient	2 ☐ ER/Outpatie	nt 3 DOA	ar M		nce 6 Other (Spe	cify)
Sion	ding P	<u>:</u>	27. Manner of Teath Natural 5 Pendin	9	of Injury th, Day Yea	r) 28b. Time o	Worl		28d. Describe ho	w injury occurred	
	Attend r death ector: by the	Certification:	2 Accident investig	not be 28e. Place	of Injury - A	At home, farm, st	reet, factory, office	Yes 2 □No	28f. Location (St	reet and Number or Ru	ıral Route Number,
5	tel or rs afte al Din ed in t	Cert	4 Homicide	build	ing, etc. (Sp	pecify)			City or Town	, State)	
	To the Hospital or Attending Physician: The law requires that the death certification 24 hours attended at the control of the things at the strength of the Fundate Director at the things completely filled in by the funeral director, page 2 should be detached for use as	edical	29a. Certifier Certifyin (Check only one) Medical	Examiner: On the b	e best of my easis of exam ner stated.	knowledge, deat nination and/or in	h occurred at the tim vestigation, in my of	ne, date and place pinion, death occu	, and due to the ca rred at the time, da	use(s) and manner as ate and place, and due	stated. to the cause(s)
	To the within: To the comple	Med	29b. Signature and title of certified		7//	n	29c. License	e number	29	9d. Date signed (Monta	h, Day, Year)
_	1		> Whi	1/1	LA	+ Wille	m 1)	35/8	3 1	ecember	20,000
0	70)		30. Name and address of person	Ma completed col	se of death	(Item 23a) (Type,	Print)	pot 1	the CI	ecember et frele. ulv	and un-
P	Sta	te	31. Date filed (Month, Day, Year)	32. F	Registrar's S	ignature	3000	1 y	- Xree	of freue	ica, M
	Registra					UE	2 3 2008	Bearing	M. GOB	de	

D. O.D. 12/22/08

Known to physicians as: Betty Rudasiii

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.

Amend Item 3 per phys. G88/ 1/23/09 dk

State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar	olato ol mary.	C	ertificate of L	Death	,	Reg. No.	
			1. Decedent's Name (First, Middle, La	ist)				2. Date of De	eath Day 2 Qar	83. Time of Beath 5
	Physicia /Medic		Ruth Ann Ro	berts				Decembe		
	Examin		4a. Facility Name (If not institution, gir			4b. City, Town, or		eath	4c. County of De	
			Kline Hospice H		yrs. last birthd	Mt. Ai		irs. 8. Date of Bi		rthplace (State or Foreign
ı	Funeral Director			1 M OFF	8 Yrs	Months   Davs	Hours M	lin.   <i>(Month, D</i> :	ay, Year) (	Maryland
	land ow	_	10a. State 10b. County	10c	. City, Town or	Location				10d. Inside City Limits
	Mary a-f sh	ctor	Maryland Freder	rick Fr	ederic	k				1 ☐ Yes 2 ☒ No
	th the	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	Country?
	ath wi		8212-C Edgewood				702	V2 - V N	United Sta	
	items	Funeral	11. Marital Status  1 ☐ Never Married 2 ☒ Married	12. Was Decedent Ever i Armed Forces? 1 ☐ Yes 2 ☑ No	in U.S.   1	<ol> <li>Was Decedent of H If Yes, specify Cuba</li> </ol>	ispanic Origin? in, Mexican, Pu	r (Specity res of No Jerto Rican, etc.)	Black, Wh	nerican Indian, ite, etc.
20	II', or	by F	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 □Yes 2 🖾 No	Specify:	Specify:	White	
5	should be filed within 72 hours after death with the Maryland nd Mental Hyglene.  marked other than "natural", or items 23a or 28a-f show marked other than "natural", or items 23a or 28a-f show matic event, the Modical Exerciper must be putilised.	Completed	15. Decedent's E (Specify only highest gr	ducation	16a. De	ecedent's Usual Occup ive kind of work done o	ation during most of	workina	16b. Kind of Busines	
7	ithin 7 ne. nan "r	mple	Elementary/Secondary (0-12)	College (1-4or 5+)	\iii	e. DO NOT use retired	1)		0 17	
Z	filed within Hygiene. other than " ent, Inc. We		17. Father's Name (First, Middle, Las	t)		Homemake		Name (First, Middle	Own Ho	me
<u> </u>	d be fi ental h red of	o Be	Walter Raymond S					et Stine		
<u> </u>	and Mental and Mental is marked o	၉	19a. Informant's Name/Relationship		19b. M	ailing Address (Street			ber, City or Town, State	, Zip Code)
- 0	and 2 ealth a n 27 is		Glenn T. Roberts	/ Husband	821	2-C Edgewoo	od Chur	ch Road,	Frederick,	MD 21702
e e	of He filter		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐			sposition (Name of crematory or other plac		Date	20c. Location - City of	
altimor	Pages ment of tant: If It is jury or o		4 Donation 5 □ Other (Spec	ify) F	Resthav	en Mem Gar			Frederick,	
	permit. Pages 1 and 2 should t Department of Health and Men Important: If Item 27 is market any injury or other traumatic once.		21. Signature of Funeral Service Lice	Inspe MIII					Funeral Ho rederick, M	
	40200		23a Part 1 Enter the disease or con	mplications that caused the	death Do not					Approximate Interval Between
	Diameteries.		23a. Part 1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final	one cause on each line.	11 1	delana -	1 2	rout	Cancer	Onset and Death
**	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a cor	nsequence of):	dvance	6 10	legi	Cancer	340 grs
	Examiner			h = = = = = = = = = = = = = = = = = = =						
	₽ #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a sor	nsequentes or):					
	executed n and ial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a cor	acourance of					
Ď,	cate be executed physician and the burial-transit			Due to (or as a cor	isequence on.					
08/00	rtificate be ng physicia as the bur	Medical		▲ d						
Xon	n certi anding use a		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pr		205-4			23d. Date of d	elivery
	w requires that the death ce been signed by the attendi should be detached for use	Physician/	in the past 12 months? 1 □Yes 2 □ No	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown		3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	У		Month	Day Year
7. O	requires that the	hys	9 🗆 Unknown				B. all	ooe Did	tobacco use contribute	to the course of death?
Š,	res th signed be de		Part II. Other significant conditions	contributing to death but not	t resulting in th	e underlying cause giv •	en in Part I.			Probably 4 🗆 Unknown
Hecords,	requi	Completed by	1.20.016	- 000	<del>~//</del>			_		
ě	ne law has b ge 2 sh	dm						— 24a. Was — auto perf	formed?   death'	autopsy findings available o completion of cause of ?
VITA	ifficate or, par		25, Was case referred to medical	1			26 Place of	1 ☐ Yes Death (Check only		es 2 No
5	ysicie is cert direct	o Be	examiner?	Hospital: 1 ☐ Inpatient	2 🗆 ER/Outpa	atient 3 DOA Oth			sidence 6 DOther (S)	Hospice
סר	ng Ph tter th neral	T:UC	27. Man of Death  1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Yea	28b. Tim	e of 28c. Injur			how injury occurred	
<u> </u>	endir eath. or: Al	catic	2 ☐ Accident investigation	on		M 1 🗆	Yes 2 □ No			
DIVISION	or Att	Certification: To	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		At home, farm pecify)	street, factory, office		28f. Location City or To	(Street and Number or sown, State)	Rural Route Number,
_	pital ours a meral I		29a. Certifier 1 Certifying F	Physician: To the best of my	v knowledge, o	eath occurred at the ti	me, date and p	place, and due to th	e cause(s) and manner	as stated.
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical		aminer: On the basis of exa and manner stated.	mination and/					
	To th withir To th comp	Me	29b. Signature and title of certifier			29c. Licens		6 (	29d. Date signed (Mo	
	1		1/2/2	2	, m	シレン	710	766	Decembe	redenice, w
	10		30. Name and address of person wh		(Item 23a) (Ty	pe, Print)	3-1	(A)	T.	Carlande
	- 01		Kanan Hudhva 31. Date filed (Month, Day, Year)	32. Registrar's S	5 /hon Signature	ras Johns	on on	re , Just	e coup	recevicie, m
	Sta Registr			32. Registrar's S	EC 23	2008	use b	Socile	,	
						The Part of the Pa		-		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician  $A^{M}$ Dec. 2008 27 7:30 Jane A. Rupert /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Columbia Howard Somerford Place If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Hours 1 M 2 KF 193 18 4647 Director 85 03-10-1923 PA Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show ral", or Items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 No Director MD Howard Ellicott City 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 4713 Wigglesworth Court 21043 United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. and 2 should be filed within 72 hours after of eaith and Mental Hygiene.
In 27 is marked other than "natural", or Itel ner traumatic event, the Medical Examiner 1 □ Never Married 2 □ Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. 3 N Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) <u>Purchasing Agent</u> Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Cyril A. Audet Margaret Duggan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health a Important: If item 27 is any injury or other trau once. Mary R. Perseghin/Daughter 4713 Wigglesworth Court Ellicott City, MD 21043 altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 12-29-2008 | Hanover, MD Ardent Crematory 4 □ Donation 5 □ Other (Specify) 22. Name and Address of FacilityHarry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee M01044 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician .5 YEARS YLZHEIMER'S /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed the burial-trai Due to (or as a consequence of): O. Box 68760, physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Year Day 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown signed by Division or Vital Records, P. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2XNo 3 ☐ Probably 4 ☐ Unknown PERTENSIO Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy 2X No 1∐ Yes 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Mother (Specify) asstd. lvg 1 Tes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 ☐ Pending investigation Injury 1 X Natural after death.

Director: Al 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours at To the Funeral D Hospital 29a. Certifier 1 💢 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

To the I

DHMH 17 Rev 1/2001

MID.

DEN RIVER PKWY

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

5653

(alum BIA

29d. Date signed (Month, Day, Year)

Dec. 29, 2008

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Year December 25, 2008 on of Death 4c. County of Death /Medical <u>Anna</u> Louise Rumreich aka Anna Louise Saliga 5:00 a.m. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Meadows at Brooke Grove Sandy Spring Village Montgomery 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral**  Birthplace (State or Foreign Country) Days Months Hours Min. 1 □ M 2 🕱 F 578-40-9846 Yrs. 94 Director March 23, 1914 West Virginia Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural, or items 23a or 28a-f show any injury or other traumatic event, it a Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 1 No Directo Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12608 Eldrid Court 20904 USA Funeral 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ₩No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2√€ No Specify: Specify: White þ 3√5 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Office Manager Travel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Michael Kopson Mary Sekala 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara J. Bergmann/Daughter 12608 Eldrid Court, Silver Spring, MD 20904 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Dec. 30, Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2008 Silver Spring, Maryland of Funeral Service Licenses 22 Name and Address of Facility Funeral Home Inc. 500 University Blvd., W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or d. m blications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List or y pne cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final End-Stage Dementia disease or condition resulting in death) 8 months **Examiner** Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of) Physician/Medical Due to (or as a consequence of): for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 → No 3 ☐ Probably 4 ☐ Unknown Hypertension þ þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? Jas certificate 1 Ves 2KJ No 1 Y68 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence & Other (Specify) Assisted ۵ 1 🗆 Yes this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death After Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Living 1 Natural 5 Pending investigation death. irector: A the fu 1 Tyes 2 No 2 Accident 6 ☐ Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) efter 4 Homicide within 24 hours of To the Funeral Di completely filled in 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D43202 December 26, 2008 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3305 N. Leisure World Blvd., Silver Spring, MD 20906

Registrar

State

Charlene Ozanne-Blankfard,

DEC 29

2008

31. Date filed (Month, Day, Year)

MD

32 Registrar's Signature

Box 68760,

Division of Vital Records, P.O.

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 25, 2008 3:00 P Virginia Kathryn Royal December 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Olney f Under 1 Year If Under 24 Hrs. Months Days Hours Min. Montgomery General Hospital Montgomery Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Social Security Number . Age (In yrs. last birthday) 1 □ M 2X F Months 579-20-0490 86 Jan 28, 1922 Washington, DC Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 1 ☐ Yes 2 ☐XNo Wicomico Maryland Salisbury 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 30055 Rolling Meadow Rd 21804 **USA** Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 📉 No Specify Specify: 3 XWidowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Joseph Ouade Kathryn Crossin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6328 Saddle Dr, Columbia, MD 21045 <u>James A. Royal, Jr./Son</u> 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) of Heaven Cem Dec 30, 2008 Silver Spring, MD Gate 21. Signature of Funeral Service License 22. Name and Address of Facility Hines-Rinaldi Funeral Home 11800 New Hampshire Ave, Silver SPring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Adult disease or condition resulting in death) Due to (or as a consequence of): Kenselerotic if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): Severe Non-IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ NO 9 Unknown 23e. Did tobacco use contribute to the cause of death? e underlying cause given in Part I. 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2

**Physician** /Medical Examiner

certificate be executed

P.O. Box 68760

Division of Vital Records,

To the Hospital or Attending

**Physician** 

/Medical

**Examiner** 

Director

Funeral

þ

Completed

Be ျှ

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Medical Exymitmer mast by ructified at once.

Baltimore, Maryland 21215-0036

Examine Physician/Medical þ Completed

attending physician and for use as the burial-transit the hed signed by the cate has been si , page 2 should t certificate eral Director: After this filled in by the funeral di death. after within 24 hours a

Be 25.

Certification: To

Medical

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

29b. Signature and title of certifier

MARIA ISABEL

9 LJ Unknown	
Part II. Other significant condition	s contributing to death but not resulting in the
Hypernatrenie	
1	

Fielt infect	ion			
Atype Troin 25. ase referred to medical				26. Place of D
txaminer? 1 ☐ Yes 2 ☐ No	Hospital: Impatient	2 ER/Outpatio	ent 3 DOA	Other: 4  Nursing
27. Manner of Death	28a. Date of Injury	28b. Time		. Injury at

eath (Check only one) g Home 5 ☐ Residence 6 ☐ Other (Specify)

28a. Date of Injury (Month, Day, Year) 28b. Time of 5 Pending investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

×	Jorlan		

and manner stated

29c. License number

20832

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NUMBUENA, MD, 1810 | Prince Philip Dr. Olney, MD

State Registrar 31. Date filed (Month, Day, Year) DEC 29



			Please	Type or Prin						
			For State	State of Ma		artment of Hertificate of D		, 0		
			Registrar  1. Decedent's Name (First, Middle, La	ist)		Tinicale of L		Reg 2. Date of Death	. No. 2008	3. Time of Death
	Physicia				mers			Month December	25, 2008	7:33 M
****	/Medic Examin		4a. Facility Name (If not institution, give	ve street and number)		4b. City, Town, or			4c. County of Dea	
api.			Southern Marylan			Clinto			Prince G	
	Funeral			1 □ M 2 🕅 E	(In yrs. last birthday, Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y) June 17,	ear) 9. Bir Co 1937 Vi	thplace (State or Foreigr ountry) .rginia
	Director		224-48-6500 Usual Residence of Decedent		71 Trs.			Julie 17,	1937	
	arylan show	_	10a. State 10b. County	Caamaala	10c. City, Town or Le					10d. Inside City Limits  10d. Inside City Limits  10d. Inside City Limits
	28a-f	ectc	Maryland Prince  10e. Street and Number	George's	OTTHE	10f. Zip Code		100	. Citizen of What Co	
1	with with the same	Funeral Director	9010 Tocca Drive			20735			United St	
	death	nera	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S. 13.	Was Decedent of His If Yes, specify Cubar	spanic Origin? (Spec	cify Yes or No-	14. Race - Ame Black, White	erican Indian,
9	or Ite	by Fu	1 Never Married Married	1 □Yes 2 N If Yes, Give	0	1 ☐ Yes 2 <b>X</b> No	Specify:	10011, 010.)	Specify:	Black
á,	hours Itural"	ed b	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's E	Year or Dates:	16a. Dece	edent's Usual Occupa	tion	16	b. Kind of Business/	/Industry
2	hin 72 9. <b>3n "na</b> Medik	Completed	(Specify only highest gr. Elementary/Secondary (0-12)	rade completed)  College (1-4or 5-	(Give	kind of work done d DO NOT use retired)	uring most of workin			
7	ygiene ygiene rer tha	Con		2 years		cord Analy			Govern	ment
2 3	be fill ntal H ad oth even	Be	17. Father's Name (First, Middle, Last				18. Mother's Name	•	iden Surname)	
À	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Help the filem 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Evandar must be notified at	욘	Randolph Pinket  19a. Informant's Name/Relationship		19b. Mail	ing Address (Street a		n Lyons  Route Number, O	City or Town. State.	Zip Code)
N .	nd 2 s alth ar 27 is r trau		Luther C. Summers		I .	Tocca Dr				-,,
ָט כ	es 1 a of Hei		20a. Method of Disposition  1 Burial 2 □ Cremation 3 □	Themselfrom State	20b. Place of Disp cemetery, cre	osition (Name of matory or other place	Da	ate 20	c. Location - City or	Town, State
	Page ment tant tant: It in the jury o		4 □ Donation 5 □ Other (Speci		Pleasant	Valley Me	m. Park J	an 2, 20	09 Annend	ale, VA
ָ מַ	permit. Pages 1 and 2: Department of Health a Important: If item 27 is any Injury or other trau once.		21. Signature of Furneral Service Lice	made 1		22. Name and Addres	s of Facility Stew	art Fune	ral Home,	Inc.
			23a. Part 1. Linter the disease, or com	nplications that caused		001 Bennin				Approximate
P	hysician		shock, I heart failure. List only Immediate Cause (Final	one cause on each lin	e.	1)	norra			Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a	a consequence of):	Trees	10000			
	Examiner	<u>_</u>	Sequentially list conditions,	b	roman a successivation of the					
	nsit	Examiner	cause. Enter Underlying Cause (Disease or injury	Dus to (or as a	i eunaequenee of):					
'n.	be executed ician and purial-transit	Еха	that initiated events resulting in death) Last	C. Due to (or as a	consequence of):					
		ical		d						
7 00 Y	leath certificate b attending physic I for use as the bi	Physician/Medical	IF FEMALE:	22 o If use outcome	of prognancy					
	atten for ug	cian	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal death 3	☐ Ectopic pregnancy ☐ Other (specify)			23d. Date of de Month	Day Year
9	t the d by the ached	hysi	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9 🗌 Unknown						
'n	gned ged oe det	by P	Part II. Other significant conditions	contributing to death bu	it not resulting in the	underlying cause give	n in Part I.			the cause of death?
5	requir een si nould b	ted		MC DI	ZEONO	4		1 ☐ Yes	2 □ No 3 □ P	robably 42 Unknown
בי בי	The law requires that the death certificate ate has been signed by the attending phys page 2 should be detached for use as the last the last last last last last last last last	Completed						24a. Was an autopsy performe	prior to	utopsy findings available completion of cause of
5	n: Ih ficate n, pag		25. Was case referred to medical	T			00 51 (5 11	1 ☐ Yes 2	No 1 ☐ Yes	s 2 □ No
5	ysicia s certi directo	o Be	examiner?  1 Yes 2 No	Hospital: 1 ☐ Inpatie	nt 2 ER/Outpatie	ent 3 DOA Othe	26. Place of Death		ce 6 🖺 Other (Spe	ecifu)
5	ng Phy fter thi neral	T:UC	27. Manner of Death  1  Natural 5  Pending	28a. Date of Injur (Month, Day	y 28b. Time		at 2	8d. Describe how		J., J.
5	tendir leath. tor: A the fu	catic	2 Accident investigation	on			′es 2 □No			
	or At after d Direct in by	Certification: To	4 Homicide determined	28e. Place of Inju building, etc	ry - At home, farm, s . <i>(Specify)</i>	treet, factory, office	2	8f. Location (Stree City or Town,	et and Number or Ri State)	ıral Route Number,
	o the Hospital or Attending Physician: The itini 24 hours after death.  of the Funeral Director: After this certificate hompletely filled in by the funeral director, page			Physician: To the best of						
:	o the Ho rithin 24 h o the Fur ompletely	edical	(Check only 2 Medical Exa	aminer: On the basis of and manner sta		nvestigation, in my op	oinion, death occurre	ed at the time, date	e and place, and due	to the cause(s)
	o i i i i i	Σ	29b Signature and title of certifier	141 10	1/ [ ]	29c. License	number	29d	l. Date signed (Mont	h, Day, Year)

Registrar

31. Date filed (Month, Day, Year) DEC 3 0 2008

30. I me and a ress of crson who completed cause of death (Item 23a) (Type, Print)

Dr. Ieon Dawson 7700 Old Branch Avenue #B-205 Clinton, MD 20735

D0047553

December 26, 2008

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Priscilla O. Stewart December 24, 2008 12:50 p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital \$ilver Spring Montgomery Birthplace (State or Foreign Country) If Under 1 Year 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2√□ F Months Days Hours Min. Director 124-24-8401 Sept. 25, 1934 New York Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐Yes 2☐No Director Maryland Silver Spring 10f. Žip Code Montgomery 10e. Street and Number 10g. Citizen of What Country? 9101 Second Avenue 20910 USA Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after I Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Exercities 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Black Specify Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Nursing Technician Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Cleveland H. Neville Priscilla M. Downer ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wanda L. Whiteside/Daughter 8609 Geren Road, Silver Spring, MD 20901 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 2 1 E Burial 2 ☐ Cremation 3 ☐ Removal from State Jan. Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2009 Silver Spring, Maryland Francis J. Collins Funeral Home Inc.
500 University Blvd. W., Silver Spring, MD 20901 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only or a cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Sepsis /Medical Due to (or as a consequence of): **Examiner** Urinary Tract Infection Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Examine Due to (or as a consequence of) that initiated events resulting in death) Last the burial-trar Due to (or as a consequence of) attending physician P.O. Box 68760 The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 🏲 No 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy signed by the atte Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by Advanced Multiple Sclerosis, Osteomyelitis, Dementia 1 Tes 2 No 3 Probably 4 1 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? certificate 1 □Yes 2 × No 1 ☐ Yes 2 ☐ No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 24 hours after death.

Funeral Director: After this etely filled in by the funeral director. 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier TEXCERTIFYING Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely and manner stated. To the within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 12-24-2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Neeraj Chopra, P.O. Box 83819, Gaithersburg, MD 20883 31. Date filed (Month, Day, Year) 32 egistrar's Signature State DEC 29 Registrar 2008

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Charles SOBEL 6:20 P 23, 2008 December /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 01ney Montgomery Montgomery General Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months Days | Hours | Min. | Ma Woon 28 ay, 1 eg/1 9 Age (1 89 (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 100-12-7261 1 X M 2 □ F **Director** New York Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a State 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 X No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20906 United States 2901 S. Leisure World Blvd., #508 death v Funeral . Was Decedent Ever in U.S. Armed Forcet?

1 Yes 2 No
If Yes, Give
Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or ite may Injury or other traumatic event, Ite Madical Examin 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 🕅 No Specify. Specify: white Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sales <u>Printing</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jenny Gold ဂ Sam Sobel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2210 Crest Knoll Road, Reisterstown, MD Paul Sobel, Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Judean Memorial Gardens 12/26/08 Olney, MD 22. Name and Address of Facility
Torchinsky Hebrew Funeral Home 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Fine) 20012 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Perforated **Physician** duodenal / /Medical Due to (or as a consequence of): Examiner fai Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Exami signed by the attending physician and a betached for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown this certificate has been s al director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an autopsy 1 ☐ Yes 25. Was case referred to medical examiner?
1 ✓ Yes 2 ☐ No Be 26. Place of Death (Check only one) To the Hospital or Attenc.

To the Hospital or Attenc.

within 24 hours after death.

"av filled in by the funeral dire." Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1. Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 29 DEC Registrar 2008

State of Maryland / Department of Health and Mental Hygiene 008 43165 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Year December 22 2008 Maheboobmiya Ramjubhai Shaikh /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Laurel Regional Hospital Laurel Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**∑**M 2□F Months Days Yrs 212-51-3425 Director 61 AUG India Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show 27 is marked other than "naturel", or Items 23e or 28a-f shov treumatic event, the Modical Examiner must be notified at 1 XYes 2 No Directo Maryland Prince George's Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9110 Elaine Court, #104 20708 death v India Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene.
Importent: If Item 27 is marked other than "naturel; or Iten any injury or other treumatic event, the Modical Exertil errones. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Š Specify: 3 Widowed 4 Divorced Asain Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 10 Dunkin Donuts 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ramjubhai Shaikh Hajrabibi Shaikh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9100 Elaine Ct. #104, Laurel, MD 20708 Sayarabibi M. Shaikh, Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Dec. 22, Maryland National 4 □ Donation 5 □ Other (Specify) Laurel, Maryland 2008 Mem. Park 22. Name and Address of Facility
Thibadeau Mortuary Service, P.A.
933 Gist Ave., LL, Silver Spring, MD 20910 21. Signature of Funeral Service Licenses M01508 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ATHEROSCLEROTIC CARDIOVASCULAR HEART DISEASE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to in hediate cause. Enter Underlying Cause (Disease or injury Examiner Directo (or as a consequer re-of): the attending physician and hed for use as the burial-transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed 1 Yes 2 100 1 Tes 2 No Physicien: 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 1 Yes 2 □ No 1 Inpatient 2. ER/Outpatient 3 □ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) Prospital or Attending Programme 24 hours after death.
Funeral Director: After to 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) To the To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) DEC 22, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Salvador Sylvester, M.D., 255 Rockville Pike, Suite 125, Rockville, MD 20850 31. Date filed (Month, Day, Year) agistrar's Signature State Registrar DEC 2 9 2008

			For State Registrar		State 0	i iviai yiai		epartifica Certifica		eann and n Death	nemai n	Reg. N	711118	43166
	Physici	an	1. Decedent's Name (Fire								2. Date of D Month	D	ay Year	3. Time of Death
	/Medic	al	Leonar  4a. Facility Name (If not a					4b. Cit	ty, Town, or	Location of Death	Decemb		c. County of Dear	1202
100	> Lxaiiii			Medica		nter			La	Plato			Char	les
-070869	Funeral Director		5. Social Security Number 219-12-36 Usual Residence of Dece	565 <sup>16</sup>	x <b>X</b> M 2□ F	7. Age (In yrs	. last birtho	Month	der 1 Year is Days	If Under 24 Hrs. Hours Min.	8. Date of B (Month, D 4 / 28 /	irth Day, Year 192	3 Mar	thplace (State or Foreign ountry) cyland
000	yland how			. County		10c. C	ity, Town o	r Location						10d. Inside City Limits
X.	ith the Marylar or 28a-f show	Director		Charl	es			Waldo						1 🔭 Yes 2 🗆 No
7	with th		10e. Street and Number					10f. 2	Zip Code	_			itizen of What Co	untry?
3	ms 23	Funeral	3006 Gall	Lery P.	12. Was Dece	dent Ever in L	J.S.	13. Was Dec	2060 cedent of His	<u>Z</u> spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or N		USA 14. Race - Ame	erican Indian,
√ √	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or items 23a or 28a-f show event, I'm Modical Evain her must be notified at	δ	1 ☐ Never Married 3 ∰ Widowed 4 ☐ I		Armed For 1 ∐Yes If Yes, Giv Year or Da	2 <b>∏X</b> No ⁄e				n, Mexican, Puerto Specify:	Rican, etc.)		Black, White	e, etc. .ack
75.5	"natul	Completed	15.   (Specify or	Decedent's Edu nly highest grad	ucation de completed)		16a. D	ecedent's Us	sual Occupa work done di	ition uring most of work	ing	16b. I	Kind of Business/	Industry
77.	within iene. than	dmo	Elementary/Secondary	y (0-12)	College (1	-4or 5+)		ne. DO NOT 1f-En				,	Farmino	4
C Pc	al Hygi other vent,	Be C	17. Father's Name (First,	, Middle, Last)				<u> </u>		18. Mother's Name	First, Middle			
<u>y</u>	should be filed and Mental Hygi marked other umatic event,	10	Milbert N			horte				Rachel		tle		
Leon	, to to =		19a. Informant's Name/F							nd Number or Rur				
	es 1 and of Health fitem 27 r other tr		Margaret 20a. Method of Disposition		s/ Sis			S1S5 isposition (N crematory or		_Ct.Sea	T PIE		ocation - City or	
ter,	Pag ment ant: I		X☐ Burial 2 ☐ Cre 4 ☐ Donation 5 ☐	Other (Specify	)	state i	-	ephs	r otner place		27/08	Por	nfret M	íD
Ball	permit. Departi Importa any inji		21. Signature	Service Licens		1	91		and Address	•	mo DA	λαι	12550 M	D 20608
5			23a. Part 1. Enter the dis shock, or heart fail	sease, or comp	lications that can		th. Do not	enter the m	ode of dying	g, such as cardiac	or respiratory	arrest,	lasco P	Approximate Interval Between
U	Physician		Immediate Cause (Final disease or condition		a	Bn	u	non	in	_				Onset and Death
	/Medical Examiner		resulting in death)		Due to 🕻	or as a consec	quence of)	-						
		Jer	Sequentially list condition if any, leading to immediate Erle Locally is	ns, late	b Due to (	or as a cons	quence of):	2						1
	scuted ind transit	Examiner	Cause (Disease or injury that initiated events		c	Dece		tus	ele	w				[]
68760,	rificate be executed og physician and as the burial-transit	a Ex	resulting in death) Last		Due to (	or as a consec	quence of):	we do	Ince-	angul	atro	_	ļ	
687	rtificate ng phys as the	Medical			d	-7/01								
P.O. Box	Attending Physician: The law requires that the death cerr death. ector: After this certificate has been signed by the attendin by the funeral director, page 2 should be detached for use a	sician/l	IF FEMALE:  23b. Was decedent pregin the past 12 mont 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	ths?		oirth 2 🗖 Fet nant at time of	al death	3 ☐ Ectopio 5 ☐ Other (					23d. Date of de Month	livery Day Year
	ires that i signed by i be detai	y Phy	Part II. Other significant						g cause give	n in Part I.	23e. Did	tobacco	use contribute to	the cause of death?
ords	v requires been sig should be	ed b	Destates	mellite	e, a	uler	ena	Jan	lane,	Congete	10	Yes 2	2 ☑ No 3 ☐ Pi	robably 4 Unknown
Division of Vital Records,	The law racate has be page 2 shu	Completed by	Heart Fa	alow ar dis	atra	Heren	rilla	in , E	pery up	Loqua	24a. Was auto perf 1 □ Yes	opsy formed?	death?	utopsy findings available completion of cause of
Vita	sician: Th certificate rector, pag	Be (	25. Was case referred to examiner?	-	Hannitalı	71				26. Place of Deat				
of o	Phys er this eral dir	: To	1 ☐ Yes 2 ☑ No 27. Manner of Death			npatient 2	28b. Tim	ne of		4 U Nursing Ho	me 5 🗌 Res 28d. Describe		6 ☐ Other (Spe	cify)
ion	ading Ph ath. r: After th	atior	1 ☑ Natural 5 [ 2 ☐ Accident	Pending investigation	(Mont	of Injury h, Day, Year)	Inju	ry M	28c. Injury Work? 1 □ Y	? 'es 2 □ No			ary cocarrou	
Divis	tal or Attendii 's after death. al Director: A ed in by the fu	Certification: To	3 ☐ Suicide 6 [ 4 ☐ Homicide	Could not be determined	28e. Place buildir	of Injury - At h	nome, farm	, street, facto	ory, office		28f. Location City or To	(Street a	and Number or Rule)	ural Route Number,
	To the Hospital or vithin 24 hours after To the Funeral Direction	Medical	29a. Certifier 12 (Check only one)	Certifying Phy Medical Exam	rsician: To the iner: On the ba and mann	asis of examin	owledge, on ation and/	leath occurre or investigati	ed at the tim on, in my op	e, date and place, pinion, death occur	and due to the red at the time	e cause( e, date ar	s) and manner as nd place, and due	s stated. to the cause(s)
	To the within 2 To the comple	Z	29b. Signature and title of	of certifier	tilel	t de	MID		D- OO	number 0837	0	29d, D	ate signed (Mont. Z - / &-	7, Day, Year) -200 8
	LB Sta	ta	30. Name and address of Paul Pritors 31. Date filed (Month, Da	vett Sk	2 MD	e of death (Ite 118 L gistrar's Sign	aGre	pe, Print)	Ave,	PO BO	(1317	- Lo	i Plata, 1	2008 MD 20646
	Registr			,	800	Mus.	H.	Sparke						

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 26, **Physician** 2008 Ρ. Thompson December Dorothy /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Southern Maryland Hospital Prince George's Clinton If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 🕱 F Months Hours Director 84 578-26-7754 Jan 7, 1924 Maryland Usual Residence of Decedent within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f show event, the "Medical Examination must be motified at 10d. Inside City Limits Maryland Prince George's Upper Marlboro Director 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9725 Wyman Way 20772 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 ☐Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 🔯 No African Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: 3 X Widowed 4 ☐ Divorced American Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry oe filed with.

Hygiene.

er than "r (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 years Accounting Assistant n and Mental Hygie Government 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked oth any injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Surname) Be George Parker Bessie Moreland 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Valerie Thompson Mersier/Daughter 9725 Wyman Way Upper Marlboro, MD 20772 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State ☐ Donation 5 ☐ Other (Specify) Jan 3, 2009 Mt. Olivet Cemetery Washington, DC ature of Funeral S 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Road, NE Washington, DC 20019 23a. Part 1: Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not ofter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Bilatera nemonia with **Physician** Failur disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) requires that the death certificate be executed and burial-tra Due to (or as a consequence of): Box 68760, attending physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.0. the 9 Unknown 9 Unknown þ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy Physician: The certificate performed 1 □ Yes 2 No 1 ☐ Yes 2 ☐ No this certific al director, 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 ☑ Natural 2 ☐ Accident 5 Pending after death

Director: / investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours aft

To the Funeral Di

completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) within 2 29b. Signature and title 29c. License number DO055 120 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SE Suk 310 Washington DC MD Krehand Valence 1328 Southern avenue 31. Date filed (Month, Day, Year) 32. Registrar's Signat State BEC 3 0 2008 Registrar

DHMH 17 Rev 1/2001

			For	State of Maryla	nd / Depa		lealth and M		iene 2008	43168
			For State Registrar		Cei	rtificate of	Death	2. Date of Deat	eg. No.	3. Time of Death
п	Physici	an	<ol> <li>Decedent's Name (First, Middle, Last)</li> <li>Freddy Jahi Trimble</li> </ol>					Month DEC 17,	Day Year	1:10 A. M
	/Medic Examin	वा -	4a. Facility Name (If not institution, give si			4b. City, Town, o	r Location of Death		4c. County of Death	<del></del>
	Examin	er	6007 44th Avenue, I			Hyattsv	ille		Prince Geo	orge's
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs	. last birthday)		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birth	place (State or Foreign
	Director		258-83-6799 Usual Residence of Decedent	24	Yrs.			May 3,	1984 Geo	rgia
	72 hours after death with the Maryland naturel', or items 23a or 28e-f show iteal Examiner must be notitied at		10a. State 10b. County	10c. C	ity, Town or Lo	ocation				10d. Inside City Limits
	Be-f s	ctor	Maryland Prince Geo	rge's Hya	attsvil					1 XYes 2 No
	with th	Directo	10e. Street and Number			10f. Zip Code			0g. Citizen of What Co	•
	s 23e	erai	6007 44th Avenue, U	Jnit #1 2. Was Decedent Ever in U	10 13	20781	lienanic Origin? /Si		United Stat	
40	fler de ritem	Funerail	11. Marital Status 1 11 Never Married 2 Married 1	Armed Forces?	i i	Was Decedent of H If Yes, specify Cuba		Rican, etc.)	Black, White	
Maryland 21215-0036	d within 72 hours after death with the Marylan jiene. I then "naturel", or items 23a or 28e-f show The Medical Examinat must be notified at	5	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2Ã No	Specify:		Specify: Bla	ack
5-0	72 h	Completed	15. Decedent's Educ (Specify only highest grade		(Give	dent's Usual Occup kind of work done	during most of wor	king	16b. Kind of Business/I	ndustry
121	within lene. then "	dmo	Elementary/Secondary (0-12)	College (1-4or 5+)	Stude	DO NOT use retired n t	1)		College	
d 2	Hyg Hyg ant,	Be Co	17. Father's Name (First, Middle, Last)		Deade	110	18. Mother's Nam	ne (First, Middle, I		
ılan	Q 22 Q 9	To B	John Alfred Trimble	2			Tendai	Jordan		
lan	S 8 8 9		19a. Informant's Name/Relationship (Typ	e, Print)					, City or Town, State, Z	
di.	item 27 l		Tendai Jordan, Moth		and the second	Lincoln Ansition (Name of	Avenue, A	-	Oakland, (	
Baltimore,	permit. Pages 1 Department of H Importent: If ite any injury or ot once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	emoval from State	cemetery, crei	matory or other plac	DHO	23,		
Ħ	artme artme orteni injury		<ul><li>4 □ Donation 5 □ Other (Specify)</li><li>21. Signature of Funeral Service License</li></ul>		25	Cremato: 2. Name and Addre	es of Facility			e, Maryland
Ba	Depar Impo any ir		> Bun M'	27.	1508   T	hibadeau 33 Gist	Mortuary	Service Silver	, P.A. Spring, MD	20910
			23a. Part 1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the dea						Approximate Interval Between
1	Pnysician		Immediate Cause (Final disease or condition	COMPLICATION	NS OF H	UMAN IMM	JNODEFICI	ENCY VIR	US	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conse	quence of):					
		ا اة	Sequentially list conditions, b.	Due to (or as a conse	quence of):					
3	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							
0	be executed sician and burial-transit		resulting in death) Last	Due to (or as a conse	quence of):					
8760,	9 % 9	dical	d							
x 68	eath certificat attending phy I for use as the	/Med	IF FEMALE:	3c. If yes, outcome of pregr	nancy				22d Date of doll	
Вох	atten atten I for u	Physician/M	23b. Was decedent pregnant in the past 12 months?  1 \( \subseteq \text{Yes}  2 \subseteq \text{No} \)	1 Live birth 2 Fell	tal death 3	Ectopic pregnancy Other (specify)	1		23d. Date of delifi Month	Day Year
Ö.	that the de led by the a detached t	hysi	9 Unknown	9□ Unknown						
s, D	The law requires that the death certifica tie has been signed by the attending ph tage 2 should be delached for use as th	by P	Part II. Other significant conditions con	tributing to death but not re	sulting in the u	nderlying cause giv	en in Part I.		pacco use contribute to	
ord	w requir been si should I							1 🗆 Ye	es 2 🗖 No 3 ☐ Pro	bably 4 Unknown
Records,	elaw has b	Completed						24a. Was a autops perforr	y prior to c	opsy findings available ompletion of cause of
al F	10 TT		OF Management and a section of					1 Tes 2	No 1 Yes	2 <b>X</b> No
Vital		o Be	25. Was case referred to medical examiner?  1 X es 2 No	ospital: 1 Inpatient 2	□ FB/Outnatier	nt 3 DOA Oth	05	th (Check only on	ence 6 Other (Spec	ihr)
J of		T:U	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o		y at		ow injury occurred	
Sior	at at	atic	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	(, 2.2)	,,		Yes 2 □ No			
Division	f or Attend after death Director: ,	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At building, etc. (Spec	home, farm, sti cify)	reet, factory, office		28f. Location (St City or Town	reet and Number or Ru n, State)	ral Route Number,
	spitel ours a nerel I		29a. Certifier 1 Certifying Phys	ician: To the best of my kr	tseb ephelwor	h occurred at the tir	ne date and place	and due to the ca	ause(s) and manner as	stated
	ne Hos	edical		er: On the basis of examinand manner stated.	nation and/or in	vestigation, in my o	pinion, death occu	rred at the time, d	ate and place, and due	to the cause(s)
	To the Hospitel or Atte within 24 hours after de To the Funerel Directo completely filled in by th	Me	29b. Signature and title of certifier	11 -	1	29c. Licens	e number	2	9d. Date signed (Month	, Day, Year)
)	V		Jaroln	12/20	30	Н5592	27	D	ECEMBER 18	2008
			30. Name and address of person who co				CHEVENT	V MADUT	AND 2070F	
	Sta	ite	SALVADOR SYLVESTER 31. Date filed (Month, Day, Year)	32. Degistrar's Sign	nature	4	, CHEVEKL	I, MAKIL	במ/טג עווא	
•	Registr		DEC 2 9 200	18 Jones .	K A	MARKET .				

			For	State	of Maryla		artment of H		and Me	•	_	2000	10166
			1 - State Registrar			Cei	rtificate of	Death				2008	
П	Physici	an	Decedent's Name (First, Middle	,	+ D T.					. Date of Dea	Day	Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution	Margare		TLUDUTT	4b. City, Town, o	r Location of		ecembe		2008 ounty of Death	1715 P <sup>M</sup>
1	LXaiiiii	CI	Union Hospita	1			Elkto	n			C	Cecil	
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 🗶 F	" ' '	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min. 8	Date of Birt (Month, Da EB 21,	th y, Year)	9. Birth	
	Director		212-74-4888 Usual Residence of Decedent		63	ris.			F.	EB 21,	1945	Vir	ginia
	yland		10a. State 10b. County		10c. 0	City, Town or Lo	cation						0d. Inside City Limits
	e Mar Ba-f s	Director	Maryland Cec	il	I	Elkton_							1 □Yes 2 No
	with th	Dire	10e. Street and Number				10f. Zip Code					n of What Coul	•
	ns 234	Funeral	10 Manor Road	12. Was Dec	cedent Ever in	U.S. 13.1	Vas Decedent of H		nin? (Specif	fv Yes or No		ited St . Race - Americ	
9	after d		1 ☐ Never Married 2 🔀 Marr	Armed F ied 1 ☐ Yes	orces? 2 🟋 No		f Yes, specify Cub	an, Mexican,	, Puerto Rio	can, etc.)		Black, White,	
933	ours a	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, G Year or			I∐Yes 2∭XNo	Specify:			S <sub>I</sub>	pecify: Wh:	ite
<u>7</u>	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ent, the Midical Even from out the muffield at	Completed	15. Deceden (Specify only highe	t's Education st grade completed,	)	(Give	lent's Usual Occup kind of work done OO NOT use retire	durina most	of working		16b. Kind	of Business/In	dustry
212	l withi giene. r than	omo	Elementary/Secondary (0-12)	College	1-4or 5+)		nemaker	-,			In	Her O	vn Home
9	al Hyg	Be C	17. Father's Name (First, Middle,	Last)				18. Mother	r's Name (F	irst, Middle,			
Maryland 21215-0036	should be fand Mental I s marked oi umatic eve	10	James C. Holb						eo Nu				
Mar	d 2 sh th and 7 is m traum		19a. Informant's Name/Relations  John W. Turnb		Uuchona	1	g Address (Street					own, State, Zi	Code)
	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Expr. finer, as the neutrical at		20a. Method of Disposition	ull, JI./			lanor Roa			е	20c. Loca	tion - City or To	own, State
altimore,	Pages nent of int: If it		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		State In	rmaculat	sition (Name of natory or other place ce Concep	tion 3	anuar 2009	- 1	Ch	erry H	i 11 MD
a	permit. Pages Department of Important: If ii any Injury or conce.		21. Signatule of Funeral Service	Licensee	160	metery	Name and Addre Lcks Home	ess of Facility	Funor	olo D	· ^	orry m	, 112
m 	20 E # 9		Doned	8. tu	cha	10	3_WSto	ckton	Stre	et, El	kton,	MD 21	921
			23a. Part 1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final	complications that only one cause on	each line.	1	les such	11		espiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician / /Medical		disease or condition resulting in death)	a. Due to	(or as a conse		45194	hmlh					
	Examiner			b Due to	(or as a conse	squerice ory.	*						
	D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a conse	equence of):							
f	ecute and I-trans	Examin	Cause (Disease or injury that initiated events resulting in death) Last	c	(or as a conse	equance of):							
8760,	icate be executed physician and the burial-transit	ia E		, Dag 10	(or as a sonse	iquonice on.							
9	tificate ng phy as the	ledical		G									
Вох	w requires that the death certifi been signed by the attending I should be detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		tcome of preg birth 2 ☐ Fe		Ectopic pregnanc	cy			230	d. Date of delive	•
0	he dea the at	ysici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 □ Preg 9 □ Unk	gnant at time o nown	f death 5	Other (specify) _					Month	Day Year
ď.	that the led by detac	/ Ph	Part II. Other significant condition	ons contributing to	death but not re	esulting in the ur	iderlying cause giv	en in Part I.		23e. Did to	obacco use	contribute to t	ne cause of death?
Records,	quires an sign uld be		Diabetes Me	elity Ty	MI	CHE	7			1 🗆 Y	/es 2 □ I	No 3□ Prob	oably 4 Unknown
9 0 0	law reas bec	Completed	Atrial Fib	rellation	, 6	UPD,				24a. Was			psy findings available mpletion of cause of
Ť	The cate h	Com	hyp- H	Mruidus	~						rmed? 2 No	death?	
VIta	ician: certifi	Be	25. Was case referre to medical examiner?	Hospital:	,		Oth	or	-	Check only o	a dimension		
ō	Phys er this eral dii	5.	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date	of Injury	ER/Outpatier	1 3 LI DOA	4 LI Nur		5 Resid		Other (Special	y)
0	nding ath. r: Afte	atio	1 Natural 5 ☐ Pendin 2 ☐ Accident investig	9	nth, Day, Year)	Injury		ki? Yes 2. □N			, ,		
Division of	r Atte	Certification: T	3 Suicide 6 Could of determining	not be ined 28e. Plac build	e of Injury - At ling, etc. (Spec	home, farm, stre	eet, factory, office		28f	Location (S	Street and N	Number or Rure	I Route Number,
	pital o		200 Cortifier 4 P Contibute	18					44	d door to the			
	To the Hospital or Attending Physician: The law requires that the death certifine 24 hours after death.  To thin 24 hours after death.  To the Funeurs after death.  Completely filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier 1 Certifylr (Check only one) 2 Medical	ig Physician: To th Examiner: On the and mai	e best of my ki basis of examii nner stated.	nowledge, death nation and/or in	estigation, in my	me, date and opinion, deatl	d place, and th occurred	at the time,	date and pl	nd manner as s ace, and due to	stated. the cause(s)
	To th within To th	Me	29b. Signature and title of certifie	4			29c. Licens				29d. Date s	signed (Month,	Day, Year)
	1		· A		123	mo		590	2		1	2/31/	08
	11		30. Name and address of person	ho completed cau	se of death (Ite	em 23a) (Type,	Print)	k has	MI	2	219	21	
	Sta	te	31. Date filed (Month, Day, Yeer)	32.	Registrar's Sign	anture	1 01	1-01	1 (		011	0	
	Registr		JAN 13	2009 2	MARAN	p. 1900	A Kara						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** 01ivia M. Vau1x December 26, 2008 07:58 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery General Hospital Olney Montgomery If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Min Months Days 1 □ M 2 🗓 F Hours 579-24-7653 85 Yrs Director 1923 Jan 7, South Carolina Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant: If item 27 Is marked other than "natural", or items 23a or 28a-f show Lry or other traumatic event, I'm Medical Examiner must be notified at 10h. County 10c. City, Town or Location 10a. State 10d. Inside City Limits Director Maryland| Silver Spring ty⊡Yes 2 □ No Montgomery 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 20906 Funeral 3210 Norbeck Road #330 United States 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. African 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 21215-0036 1 □Yes 27 No Specify 2 American 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Teacher's Aide Government Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Solomon Montague Mary Berry 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LaShawn Deville - Daughter 4908 Melinda Court Rockville, MD 20853 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. 4 Donation 5 Other (Specify) Jan 3, 2009 Cedar Hill Cemetery Suitland, MD 22. Name and Address of Facility Stewart Funeral Home, Inc. nature of Funeral 4001 Benning Road, NE Washington, DC 20019 23a. Part 1. Stater the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Severe SEPS15 /Medical Due to (or es a consequence of): Examiner Rene Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed sician and burial-tran Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical as the IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 🗆 Ectopic pregnancy jo Month Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2 No detached 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> Costridum 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy performed? 1 ☐ Yes 2 ☑ No certificate 1 ☐ Yes 2 ☐ No director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient ို 2 ER/Outpatient 3 DOA funeral Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? Certification: 27. Manner of Death 28d. Describe how injury occurred 1. Natural 5 Pending investigation death. I Director: And in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 \( \text{Homicide} \) within 24 hours a

To the Funeral C

completely filled filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical end manner stated.

State Registrar

29b. Signature and title of certifier

3 0

2008

P. ISABEL 31. Date filed (Month, Day, Year) 32. Registrar's Si

and address of person who completed cause of death (Item 23a) (Type, Print)

29c, License number

D65292

Olney, MD

29d. Date signed (Month, Day, Year)

12/26/08

18101 Prince Phillip Drive

State of Maryland / Department of Health and Mental Hygiene 2 0 1 - For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Juanita Madron Vidi December 25, 2008 6:27 p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery General Hospital Olney Montgomery 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 □ M **X**X F Director 577-12-9178 88 Oct. 12, 1920 Virginia Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a State 10d. Inside City Limits 28a-f show 1 ☐ Yes 2 🛣 No Director traumatic event, the Medical Examiner must be notified Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 712 Quaint Acres Drive 20904 USA Funeral or items, 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces? 1 □Yes 2 ₩ No 72 hours after 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify: þ White Specify: 3 Widowed 4 □ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 U.S. Dept. of Interior Personnel Officer marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 12 should be fi. h and Mental F 7 Is marked otl Be ပ Robert Monroe Madron Eva Mae Penn 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Peter R. Vidi, Jr./Son 13100 Isle of Mann Way, Highland, MD 20777 permit. Pages 1 and:
Department of Health
Important: If item 27
any injury or other tr. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Dec. 30 Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2008 Silver Spring, Maryland 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licens 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only operause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final FAILURE RESPIRATORY **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner WEEKS HYPERTENSION PULLMONARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) be executed and burial-tran resulting in death) Last Due to (or as a consequence of) Box 68760, physician the burial Physician/Medical law requires that the death certificate attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) detached 1 ☐ Yes 2 MNo Ö 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Records, ğ. been si 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s. autopsy Physician: The certificate performe Vital 1 □Yes 2 **N**o 1 ☐ Yes 2 ☐ No After this certification 25. Was case referred to medica Be 26. Place of Death (Check only one) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Hospital or Attending 5 Pending after death.

I Director: Af
d in by the fur 2 Accident Investigation 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide filled in 24 hours a Medical 29a, Certifie 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only ATTENDING 29c. License number 29d. Date signed (Month, Day, Year) (MR D34740 PHYSICIAN Name and address of person who completed cause of death (Item 23a) (Type, Print) PHILIP DR # 200 - OLNEY ROBERT 31. Date filed (Month, Day, Year) 2. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

			For State Registrar		State	of Maryla		artment of F rtificate of		Mental Hy	giene Reg. No. 2	008	43172
	Physici	an	1. Decedent's Name	(First, Middle	, Last)					2. Date of De Month	ath		3. Time of Death
	/Medic		Janet S.	Verne	r					12	Day 2 7	Year 2008	1:45 PM
	Examin	ıer	4a. Facility Name (If I	not institution	, give street and r	number)		4b. City, Town, or	r Location of Deatl	n	4c. Cou	nty of Death	1 10 15
and.			Rockville	Nursi	ng Home			Rockvil:	le		Mont	gomery	7
	Funeral		5. Social Security Nu	mber	6. Sex 1 ☐ M 2 ☐ F	7. Age (in yrs	s. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th		lace (State or Foreign
	Director		135-20-38	38		82	Yrs.	Bays	, riodio Milli.	11-22-			Jersey
	and		Usual Residence of D	Decedent 10b. County		100.0	City, Town or Loc	cation	-				
	/aryl	ō		Montgo	m o r v		ockvill						0d. Inside City Limits 1-√2 Yes 2 □ No
	filed within 72 hours after death with the Maryland Hygene. bther than "natural", or items 23a or 28a-f show ant, tre Marical Examiner must be refifted at	Director	MD 10e. Street and Numb		шегу	I.	OCKVIII				10 000		21
	with ga or							10f. Zip Code			10g. Citizen	of What Coun	itry?
	eath	Funeral	9405 Blac	kwell :		2 cedent Ever in l	18 12 1	20850	inneria Oriaino (O			S.A.	
<b>'</b>	fter d riten iner	Ē	1 ☐ Never Married	d 2□ Marria	Armed F	Forces?	J.S. 13. V	Vas Decedent of H f Yes, specify Cuba	an, Mexican, Puert	pecity res or No o Rican, etc.)		Race - Americ Black, White, e	
3	urs al	δ	3 ☐ Widowed 4		If Yes, C	: 2 X No Give X Dates:	1	∐Yes 2 <mark>K</mark> No	Specify:		Spe	cify: Whi	te
Ģ	2 hou	Completed	1	5. Decedent's	s Education		16a. Deced	lent's Usual Occup	ation			Business/Inc	
2	hin 7.	ble	(Specify Elementary/Second	y only highest	t grade completed		(Give I	kind of work done of OO NOT use retired	during most of wor	king	100.11.10.01	Du3/116	lustry
7	d with	)om	Licinental y/3600110	daiy (0-12)	4	(1-4or 5+)	Sch	ool Teach	ner		Pub	lic Sc	hools
g	e file al Hy othe vent,	Be (	17. Father's Name (F	irst, Middle, L	.ast)		<u> </u>		18. Mother's Nam	ne (First, Middle,	Maiden Surn	ame)	
<u>a</u>	uld b Ment Irked Itic e	To E	Hyman Sch	nlven					Clara S	chneid			
Maryland 21215-0036	ages 1 and 2 should be filed we and of Health and Mental Hygien It. If Item 27 Is marked other thy or other traumatic event, It. It	'	19a. Informant' - an		ip (Type. Print)		19b. Mailin	g Address (Street			er, City or Tov	vn, State, Zip	Code)
Σ	and and 27 n 27 er tr		Sid Verne	er / H	usband		9405	Blackwell	L Road #	102 Roc	kville	MD 20	850
<u>S</u>	of He		20a. Method of Dispo				Place of Dispos			Date		n - City or To	
altimore,	Pages nent of ant: If its ary or o		4 ☐ Donation 5		3 □ Removal fron <i>ecify)</i>	Ga:		Remembra		0/08	Clark	sburg,	MD
a	permit. Pages Department of Important: If i any injury or one	Ì	21. Signature of Fund	eràl Service L	icensee	//	22.	Name and Addres	s of Facility			-	
n	80 = 80		115	-	-	1/12	11	70 Rockv	ille Pike	Memoria Rockv	ille M	n 2085	.nc
			23a. Part 1. Enter the	disease, or o	complications that	caused the dea	th. Do not ente	er the mode of dyin	g, such as cardiac	or respiratory ar	rest,	<u>D 20</u> 03	Approximate
F	hysician	å a	Immediate Cause (Fi		,							1	Interval Between Onset and Death
	/Medical		resulting in death)			er of Co o (or as a consec							years
	Examiner				b. Pneur		,						
,	B +	ner	Sequentially list condificant, leading to immediate. Enter University Cause (Disease or inj	itions, ediate		(or as a consec	quence of):					1	nonths
2	ocute nd ransi	Examiner	triat initiated events	1	c. Deme	ntia						7	years
, ,	e exe ian a urial-1	ŭ!	resulting in death) Las	st	Due to	(or as a consec	quence of):						, 0025
08/60,	res that the death certificate be executed signed by the attending physician and be detached for use as the burial-transit	edical			d								
õ	ing p	Med	IF FEMALE:	-							1		
ž P	th ce	sician/M	23b. Was decedent pr			utcome of pregn		Ectopic pregnancy			23d. E	Date of deliver	ry
5	e dez	sici	in the past 12 mo	No		gnant at time of		Other (specify)			1	Month I	Day Year
1	at the	ᇍ	9 ☐ Unknown 1										
<u>က်</u>	es the de	þ	Part II. Other significa	ant condition	s contributing to	death but not res	sulting in the und	derlying cause give	n in Part I.	23e. Did to	bacco use co	ntribute to the	e cause of death?
	pluo sen s									1 □ Y	es 2 □ No	3 🗌 Proba	ably 4 🔼 Unknown
Hecords,	as bi	Completed								24a. Was a		. Were autop	sy findings available
ב ב	ate h	ĕ								autop: perfor	med?	death?	pletion of cause of
VITAL	ysician: The is certificate his director, page	Be	25. Was case referred examiner?	to medical					26. Place of Deat			1 □Yes	2 [_]NO
>	nysic his ce I dire	၉	1 Yes 2√2 No	)	Hospital: 1	Inpatient 2	ER/Outpatient	3 □ DOA Othe	-	me 5 Resid		ther (Specify	)
5 8	ng P		27. Manner of Death 1 ☑ Natural	5 Pending	28a. Date	of Injury oth, Day, Year)	28b. Time of Injury	28c. Injury Work	at	28d. Describe h			,
0 0	endingsath.	iğ	2 Accident	investiga	tion	, 22, 102.7	,,		es 2 □ No				
	rector	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could no determin	ed   28e. Place	e of Injury - At hi	ome, farm, stree	et, factory, office		28f. Location (S. City or Town	treet and Nun	nber or Rural	Route Number,
ב כ	rs af	Š							4	City of Town	r, state)		N.
000	t hour times and	<u>a</u>	29a. Certifler (Check only 2)	Certifying	Physician: To the	e best of my kno	owledge, death	occurred at the timestigation, in my op	e, date and place,	and due to the d	ause(s) and	manner as sta	ated.
94	To use hopping or surfacting prysician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical			and mar	nner stated.	and/or mye	Jonganon, in my op	milon, death occur	red at the time, d	are and place	, and due to t	rne cause(s)
Ē		2	29b. Signature and title	e of certifier	1 1	a	4 -	29c. License	number	2	9d. Date sign	ed (Month, D	ay, Year)
	3		P str	our	) U.	Jusy	9	D00473	30		12/28	3/08	
			30. Name and address										
			Thomas V J						_	1 0.0			
					50 W. H			Suite 207	Rockvil.	Le MD 20	852		
	State Registra	е	31. Date filed (Month.		32	Edmonsto Registrar's Signa	ature	Suite 207	Rockvil	Le MD 20	0852		

DHMH 17 Rev 1/2001

Registrar

DEC 3 0 2008

1 - For State Registrar 1. Decedent's N

Director

Funeral

Completed by

To Be

Examine

Physician/Medical

Completed by

Be

Certification: To

Medical

29a. Certifier (Check only one)

**Physician** 

/Medical

Examiner

**Funeral** Director

		•				Ensure Al			
For State Registrar		State of Ma	iryiand /	•	tificate of	lealth and M <i>Death</i>		ene 1. No. 2 A A S	0 1.2171.
	e (First, Middle, Last)						2. Date of Death Month	Day Year	3. Time of Death
Jane L.	Williams						12	23 2008	7:00p. M
	If not institution, give st					r Location of Death		4c. County of De	
St. Thor	mas More Nu	rsing Ho	me & Re	eh.	Hyatts\	Jille If Under 24 Hrs.	8. Date of Birth	Prince (	rthplace (State or Foreign
227-40-9 Usual Residence of	9455	M 2 <b>⊠</b> F	78	Yrs.	Months Days	Hours Min.	(Month, Day, Y 10/8/193	(ear)	VA
10a. State	10b. County		10c. City, Tov	wn or Loc	cation				10d. Inside City Limits
MD	Prince Ge	eorge's	Fort V	Wash:	ington				1X Yes 2 No
10e. Street and Nu	mber				10f. Zip Code		100	g. Citizen of What C	·
2009 Thi	stlewood D				20744			USA	
<ul><li>11. Marital Status</li><li>1 ☐ Never Mari</li><li>3 ☒ Widowed</li></ul>	ried 2 Married	2. Was Decedent I Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:			Vas Decedent of H f Yes, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify:	
/Sno	15. Decedent's Educa		16	a. Deced	ent's Usual Occup	ation during most of work	ina 16	6b. Kind of Busines	s/Industry
Elementary/Seco		College (1-4or 5	+)	Nur	OO NOT use retired	gamig moot of wom.		Medical/H	ospital
17. Father's Name	(First, Middle, Last)	-				18. Mother's Name	(First, Middle, Ma	aiden Surname)	
Ned Book	er					Elizabet	h Smith		
	ame/Relationship (Type		1			and Number or Run			Zip Code)
	. Williams	/Son				ood Dr.,			744
	position □Cremation 3 □Re 5 □ Other ( <i>Specify</i> )	moval from State	Manas	tery, cren ssa H	sition (Name of natory or other place Lill Bapt Cemetery	ist .	Pate A1 28/2008	oc. Location - City of melia Cou VA	r Town, State irt House,
21. Signature of F	uneral Service Licerse	1		22	. Name and Addre	ss of Facility St ntown Rd.		Funeral	
23a. Parti. Enter	the disease, or complic	ations that caused	the death. Do						Approximate
shock, or hea	art failure. List only one	e cause on each lir Cénal	ie.			usis te		2	Interval Between Onset and Death
disease or condition resulting in death)	on a.		a consequence		CDIA	4315 (4	TEMINAT	-41	neon Th 3
Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or	onditions, b. nmediate erlying	Due to (or as	a consequence	e of):					
that initiated event: resulting in death)	S C.	Due to (or as	a consequence	e of):					
	L <sub>d</sub> .								
IF FEMALE: 23b. Was deceder in the past 12	months?	ic. If yes, outcome 1□Live birth 4□Pregnant at	2 Fetal dea		Ectopic pregnance Other (specify)	y		23d. Date of d	elivery Day Year
1 ∐ Yes 2j 9 □ Unknowr		9□Unknown							
4	real exfa	-	A		nderlying cause giv			cco use contribute 2 ☐ No 3 ☐ F	to the cause of death?  Probably 4@Unknown
Corona	any Arri	eny Dis					4 2a. Was an autopsy	24b. Were a	autopsy findings available o completion of cause of
Ence	Shalopa	my D.	abete	s W	dellitus		performe	ed?   death?	s 2 No
25. Was case refe examiner?							h (Check only one)		
1 ☐ Yes 2 ☐	LIVO		nt 2 ER/C		t 3□ DOA Oth	er: 4 Nursing Ha			ecify)
27. Manner of Dea 1 Natural 2 Accident	5 ☐ Pending investigation	28a. Date of Inju (Month, Day	Year)	. Time of Injury	M 1□	ry at k? Yes 2 □ No	28d. Describe how	injury occurred	
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of inju- building, et	ry - At home, c. (Specify)	farm, stre	eet, factory, office		28f. Location (Stre City or Town,	et and Number or I State)	Rural Route Number,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division or Vital Records, P.O. Box 68760,

Physician /Medical

State Registrar

A. 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

DEC 3 0 2008

29c. License number D01852 29d. Date signed (Month, Day, Year) DECEMBER 26, 2008

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

represent Pal Hyattsville Mi) 20181 V) = VURE MB 4203 Qu

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

DEC 3 0 2008

6

10.5

12/24/08@

Whitingham

-ucille

			For State Registrar		State of Ma	ryland		artment of F ctificate of I		Mental Hy	giene Reg. No 2 (	800	431	76
ı	Physicia	an	1. Decedent's Name (Fin	rst, Middle, Last)	rie. W	EL	LS			2. Date of De Month Decem	Day	Year 2008	3. Time of	f Death 36 Am
	/Medic Examin		4a. Facility Name (If not					4b. City, Town, or	Location of Death			unty of Death		
	LXaitiiii	CI	Howard Cou	nty Gene	eral Hospi	tal		Colum			Ho	oward		
I	Funeral Director		<ol> <li>Social Security Number</li> <li>212 01 659</li> </ol>	. 1 □	IM OFFICE	(In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 10–21–	y, Year)	9. Birth Cou MD	nplace (State o untry)	or Foreign
	and w		Usual Residence of Dec	edent c. County		10c. City.	Town or Lo	cation					10d. Inside Ci	ity Limits
	Maryla f sho	Po	MD	Howard				City					1 □Yes	2 <b>X</b> No
	r 28a-	Director	10e. Street and Number		1	تحدث	LIWL	10f. Zip Code			10g. Citizen	of What Cou	intry?	
	h with	a D	4516 Stone	crest Di	cive			210	43		Uni	ted St	ates	
	ems ?	Funeral	11. Marital Status		12. Was Decedent E	ver in U.S.	13. \	Was Decedent of H	ispanic Origin? (Span, Mexican, Puerto	pecify Yes or No Rican, etc.)	- 14.	Race - Amer Black, White,		
0500-c	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, it is modical Example must be notified any once.	þ	1 ☐ Never Married 3 🔀 Widowed 4 ☐		1 ∐Yes 2 XNo If Yes, Give Year or Dates:	0		I∐Yes 2⊠No	Specify:			ecify.	hite	
ה ה	72 hc	etec	15. (Specify o	Decedent's Edu	cation e completed)	Į.	(Give	dent's Usual Occup kind of work done	during most of work	king	16b. Kind o	of Business/Ir	ndustry	
Z	within ene. <b>than</b>	Completed	Elementary/Secondar	y (0-12)	College (1-4or 5+	-)		oo NOT use retired cutive Se	<b>,</b>		Marrell:	oT. Bre	ckey C	lub
7	filed Hygin	Be Co	17. Father's Name (First	t, Middle, Last)			LACC	active be	18. Mother's Nam	e (First, Middle,			CACY C.	<u></u>
land	fid be fental rked c	To B	Walter Can	app					Leila Mu	ıllineau	ıx			
ary	s mai	-	19a. Informant's Name/	Relationship (Ty	pe. Print)		19b. Mailin	g Address (Street	and Number or Ru	ral Route Numb	er, City or To	wn, State, Z	ip Code)	
Σ.	and 2 ealth n 27 I		Dawn M. Boy	wser/Dau	<i>ighter</i>				st Drive					
ore	ges 1 t of H if iter or oth		20a. Method of Dispositi 1 ☐ Burial 2 🖵 Cr		Removal from State			sition (Name of natory or other plac	e)	Date		ion - City or T		
аппто	t. Pag rtmen rtant:		4 □ Donation 15 □	Other (Specify)				ematory		27-2008				_
מ	permi Depa Impo any Ir		21. Signature of Funera	allin	- culptu	101044	4	1112 Old	<sup>ss of Facility</sup> Har Columbia	Pike El	licot			
			23a. Part 1. Enter the di shock, or heart fai	isease, or compl ilure. List only or	ne cause on each line	e.							Approximate Interval Bet Onset and I	tween
1	Physician		Immediate Cause (Fina disease or condition resulting in death)	al				CARCI	NOMA	of let	t bre	est	Yes	
	/Medical Examiner			one I	Due to (or as a	conseque	nce of):							
	uted d ansit	Examiner	Sequentially list condition any, leading to mined cause. Enter Underlying Cause (Disease or injurthat initiated events	g diate	Due to (or as a	consequa	nee-oily							
68/60,	ificate be executed g physician and is the burial-transit	al Exa	resulting in death) Last		Due to (or as a	conseque	nce of):							
200	ificate g phys is the	edical			1	7175,77								
O. BOX	w requires that the death certif been signed by the attending should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pre in the past 12 mon 1 □ Yes 2 ☑ No 9 □ Unknown	nths?	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at 9 Unknown	2 🗌 Fetal d	leath 3	Ectopic pregnanc Other (specify) _	у		23d	. Date of delive Month	•	Year
JS, F.	requires that the been signed by th hould be detache	þ	Part II. Other significant	ot conditions con	4	t not resulti	ing in the u	nderlying cause giv	en in Part I.				the cause of d	
000	v requ been shouk	etec	- 01	any a	as	seas	.e			24a. Was	T		topsy findings	
Vital Records,	The larate has	Completed	478.	الم الماء	dism 4			ulk riti	3 5	auto perfo		prior to co death?	ompletion of c	ause of
<u> </u>	Physician: r this certific ral director,	Be	25. Was case referred t examiner?	-	Hospital:		0.0	ot all DOA Oth	26. Place of Dea			10.1		-
0	J Physer this eral di	n: To	1 Yes 2 No 27. Manner of Death		28a. Date of Injur	y 2	8b. Time of	IL 3 DOX	4 🗆 Nursing n	ome 5 ☐ Resi 28d. Describe			<u>ify)</u>	
vision	ath. r: Afte	atio	1 ☑ Natural 5 2 ☐ Accident	Pending investigation	(Month, Day	(Year)	Injury		K? Yes 2□No					
DIVIS	al or Atte s after de l Directo d in by th	ertification:	3 ☐ Suicide 6 4 ☐ Homicide	Could not be determined	28e. Place of Injurbuilding, etc.	ry - At hom (Specify)	ne, farm, str	eet, factory, office		28f. Location ( City or To		umber or Rui	ral Route Num	nber,
	To the Hospital or Attending Pl. within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Medical C			sician: To the best of ner: On the basis of and manner stat	examination								s)
<b>—</b>	within Volume	Me	29b. Signature and title	B. Was	llet				30469		المالية	igned (Month	26 2	2003
	×E6		30. Name and address	of person who co					ckny b	308	Colum	, ברפו	Mp. 2	1045
Ì	Sta Registr		31. Date filed (Manth D	Day,-Year) C. 2. 9. 200	8 Cerem	s Signatu	. So	aled						

State of Maryland / Department of Health and Mental Hygiene 4317 Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Dav Year **Physician** 2146 Dec 23 2008 E. Williams Marv /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Chever1y
If Under 1 Year | If Under 24 Hrs. Prince Georges Prince Georges Hospital 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 STE Sep 26 79 1929 North Carolina Director 239-54-7668 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Heath and Mental Hygiene. ant. If item 27 is marked other than "natural", or items 23a or 28a-4 show ary or other traumatic event, the Medical Examinations and by notified at 1√TYes 2 No Director DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20019 201 58th St. NE #316 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White etc. 1 ∐Yes 2 ⊠No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: <u>≽</u> Specify: 3 X Widowed 4 ☐ Divorced Black. Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10th Food Services Trinity College 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Davis Rhoda Russell ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 Is any Injury or other trau once. Tyrone I. Williams/Son 5808 Delta Lane Camp Springs, MD. 20746 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harmony Memorial Park 12-31-2008 Landover, MD. 22. Name and Address of Facility
Murray Funeral Home 21. Signature of Funeral Service Licenses 4804 Georgia Ave. NW Washington, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Fatal Cardiac Arrhythmia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physlcian: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 □Yes 2 🖾 No ed by the 9 Tilnknown cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Atherosclerotic Heart Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Chronic Obstructive Pulmonary Disease autopsy performed? 1 □ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 🖾 ER/Outpatient 3 ☐ DOA Certification: To in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation 1 13 Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a Filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 and manner stated. 29b. Signature and the of certific 29d. Date signed (Month, Day, Year) 29c. License number 0 30. Name and address of person, who completed cause of death (Item 23a) (Type, Print) Gary Little, MD 3001 Hospital Dr. Cheverly, MD. 20785 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar DEC 29

			State of Maryland / Department of I  1 - State Registrar  State of Maryland / Department of I  Certificate of			ene 2008	3 43178
	<b>D</b> (		Decedent's Name (First, Middle, Last)	2	2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		Flora J. Wertheim		December	22, 2008	
	Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, C	or Location of Death		4c. County of Deat	
	_		Holy Cross Hospital  5. Social Security Number   6. Sex   7. Age (In yrs. last birthday)   If Under 1 Year	ver Spring	8. Date of Birth	Montgom 9. Birt	ery hplace (State or Foreign
	Funeral Director		1	Hours Min.	(Month, Day, Y	ear) Co	many
	pu »		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	f shoved	ō					1 ☐ Yes 2 📉 No
	the N	Director	Maryland Montgomery Silver Spring  10e. Street and Number 10f. Zip Code		10g	. Citizen of What Co	untry?
	h with		1131 University Blvd, West, #520 20902			USA	
	ems S	Funeral		Hispanic Origin? (Spec oan, Mexican, Puerto Ri		14. Race - Ame Black, White	
20	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, the "Ledical Eventinal matter or cliffed at once.	by Fu	1 ☐ Never Married 2 ☐ Married		,	Specify:	
2-003e	hour tural		3 ☐ Widowed 4 ☐ Divorced Year or Dates:  15. Decedent's Education 16a. Decedent's Usual Occu	pation	16	b. Kind of Business/	White Industry
2 2	en "na In "na	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  16a. Decedent's Usual Occu (Give kind of work done life. DO NOT use retire)	during most of working	9		·
7	ygiene /giene er tha	Con	12 Homemaker	_		Own Hom	е
and	be file Ital Hy Id oth event	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (	(First, Middle, Ma	iden Surname)	
3	2 should be filed within 7 and Mental Hygiene. is marked other than "raumatic event, in the "raumatic	٦	Hans Jonas David  19a, Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Stree	Lily We		Situat Taum Ctata	Zin Codo)
<u>8</u>	id 2 sh lth an 27 is r traur						ip Code)
ē,	s 1 ar if Hea item 2		Hedy Ohringer/Daughter 5014 Rodman 20a. Method of Disposition (Name of cemetery, crematory or other pla			c. Location - City or	Town, State
Ē	Page nent o int: If iry or		1 ★Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)  Mt. Lebanon Ceme	i	24, 2008	Ade1ph:	i, MD
Saltimor	permit. Departn Importa any inju			ess of Facility Hine			
מ	9 Q E # 9						ng, MD 20904
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dy shock, or heart failure. Disponly one cause on each line.		respiratory arrest	i,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  Cardiorespiratory	Arrest			
تمي	Examiner		Due to (or as a consequence of):    Sequentially list conditions   Due to (or as a consequence of):	11ation			
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	TIACION		- 2	
2	ecuted ind transi	Examiner	that initiated events c. Acute Try ocar did	Infarction			
Ď,	be exician gourial-		resulting in death) Last Due to (or as a consequence of):				
58/60,	fficate be executed g physician and is the burial-transit	edical	d				
ROX	certi iding se a		IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of del	livery
	death ne atten ad for u	Physician/M	in the past 12 months?  1  Yes 2 No  1  Yes 2 No  1  Yes 2 No			Month	Day Year
r. O	w requires that the de been signed by the should be detached	Phys	9 Li Unknown		One Did to be		Abo course of death?
S,	ires th signer	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause gi	ven in Part I.			the cause of death?
ecord	requ been should	eted	Hypertension				
ě	e la has e 2	Completed			24a. Was an autopsy performe 1 □ Yes 2X	prior to o	rtopsy findings available completion of cause of
VITAI	ilcian: The certificate ector, pag		25. Was case referred to medical	26. Place of Death		□No 1 □ Yes	2 🗆 No
<u> </u>	nyslcia nis cer direct	To Be	examiner? 1 Yes 2 XNo  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Ot	hor:	, ,	ce 6 ☐ Other (Spe	cify)
n 01	ng Ph ifter th ineral	on: 1	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury Wo	ıry at 28 ırk?	8d. Describe how	injury occurred	
210	tendi leath. tor: A the fu	cati	2 Accident investigation M 1	]Yes 2□No	26 1		
DIVISION	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifical completely filled in by the funeral director,	Certification:	3 ☐ Suicide 4 ☐ Homicide  3 ☐ Suicide 4 ☐ Homicide  5 ☐ Could Not be determined building, etc. (Specify)	26	City or Town, S	et and Number or Ru State)	ural Houte Number,
	spital nours neral y filled	a C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the	time, date and place, a	nd due to the cau	se(s) and manner a	s stated.
	he Ho n 24 h he Fu	ledical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my and manner stated.	opinion, death occurred	d at the time, date	and place, and due	to the cause(s)
	To t To t	Ž	29c. Licen	se number	29d	. Date signed (Mont	h, Day, Year)
	12		A	D68096		December	22, 2008
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	Corina M	n 20010		
	Sta	te	Satyam A. Shah 1500 Forest Glen Rd, Silver  31. Date filed (Month, Day, Year)  32 Registrar's Signature	opring, MI	D 70310		
	Registr		DEC 2 9 2008 Signed It for the state of the				

Lillian Weitzman  Facility Name (If not institution, give  Montgomery Gener  Social Security Number  132-09-5745  Facility Residence of Decedent  Facility Maryland Montgo  Facility Montgo  Facility Residence of Decedent  Facility Montgo  Facility Residence  Facility Residen	Rd. #218  12. Was Decedent Ever Armed Forces? 1	90 Yrs. 90 C. City, Town or Silver er in U.S. 1: 16a. Dec (Gi life C 19b. Ma 1423 1422 20b. Place of Discemetery, co	Oliminary   If Under   Months	Code D906 Pent of Hispa for Code during retired)  [Cocupation ( done during retired)  [Cocupation ( do	Mother's Na Bertha Number or F re, Roo FacilityHii	Specify Yes or Norking  The Control of Burne 2  Specify Yes or Norking  Specif	10g. Citizen of V  USA  10- 14. Rac Blac Specify  16b. Kind of Bi  Depar e, Maiden Surnan ber, City or Town,  MD 2085 20c. Location- 008 Olr  1ddi Fune	y of Death  gome 9. Birth Cou  New  What Cou  What Cou  What Cou  State, Zi  City or They,  eral	Pry Inplace (State or Fountry)  V York  10d. Inside City Li 1  Yes 2 X  Intry?  Intry?  Interpretation  Interp
Social Security Number  132-09-5745  Sual Residence of Decedent a. State  10b. County  Maryland Montgo e. Street and Number  14508 Homecrest  Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  15. Decedent's Ed.  (Specify only highest grace)  Elementary/Secondary (0-12)  12  The Eather's Name (First, Middle, Last)  Paul Yanowitz  Da. Informant's Name/Relationship (7)  Paula Sendroff Da.  Method of Disposition  1 Burial 2 Cremation 3 Diversity  1 Signature of Funeral Service Licenses  3a. Part 1. Enter the disease, or composhock, or heart failure. List only composite or condition  1 Sease or condition	Rd. #218  12. Was Decedent Even Armed Forces? 1   Yes 2   No If Yes, Give Year or Dates:    Ucation   Was Decedent Even Armed Forces? 1   Yes 2   No If Yes, Give Year or Dates:   Ucation   Was Decedent Even Armed Forces?   Type. Print)   College (1-4or 5+)   Type. Print)   Removal from State   Was Deceded Inc.   Was	90 Yrs. 90 C. City, Town or Silver er in U.S. 1: 16a. Dec (Gi life C 19b. Ma 1423 1422 20b. Place of Discemetery, co	Spring    Total Control   Spring	Days H  Days H	mic Origin? (lexican, Puer pecify:  Mother's Na Bertha Number or F re, Ro	Specify Yes or Norto Rican, etc.)	10g. Citizen of V  USA  10-  16b. Kind of Bi  Depar  e, Maiden Surnan  ber, City or Town,  MD 2085  20c. Location-  108 Olr  11di Fune	New What Cou Dee - Americk, White, Whusiness/Ir Ctmen State, Zi City or They,	nplace (State or Fountry)  10d. Inside City Li 1 □ Yes 2 Y  untry?  rican Indian, , etc.  nite ndustry  typ Code)  Town, State  MD  Home
isual Residence of Decedent a. State  10b. County  Maryland Montgo e. Street and Number  14508 Homecrest  Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced  15. Decedent's Ed. (Specify only highest grace  Elementary/Secondary (0-12)  12  The Father's Name (First, Middle, Last)  Paul Yanowitz  Ba. Informant's Name/Relationship (7)  Method of Disposition  1 Burial 2 Cremation 3 Method of Disposition  1 Burial 2 Cremation 3 Method of Disposition  1 Signature of Funeral Service Licenses  3a. Part 1. Enter the disease, or componed sease or condition  1 Sease or condition	Rd. #218  12. Was Decedent Every Armed Forces? 1	90 0c. City, Town or Silver er in U.S. 13 16a. Dec (Gi life C 19b. Ma 1423 1423 20b. Place of Discemetery, co. Judean	Spring 10f. Zip 0 20 3. Was Decede If Yes, speci 1  Yes 2 cedent's Usual ve kind of work DO NOT use liling Address ( 6 31  Arct position (Name rematory or oth Memoria 22. Name and	Code  D906  ent of Hispa fly Cuban, N  Occupation ( done durin e retired)  18.  Enclude Ave e of her place) Address of New Ha	nic Origin? (lexican, Puer pecify:  Mother's Na Bertha Number or F re, Roe FacilityHii	Specify Yes or North Rican, etc.)  orking  me (First, Middle Jebrock Rural Route Num ckville, Date c 28, 20 nes-Rinare Ave,	10g. Citizen of V  USA  14. Rac Blac Specify  16b. Kind of Bu  Depare, Maiden Surnan  ber, City or Town,  MD 2085  20c. Location-  008 Olr	New What Cou se - Americk, White, y: Whusiness/Ir ctmen State, Zi City or T ney, eral	v York  10d. Inside City Li 1 □ Yes 2 v  untry?  rican Indian, , etc.  nite ndustry  try  code)  Town, State  MD  Home
Maryland Montgo e. Street and Number  14508 Homecrest . Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Ed. (Specify only highest grace) Elementary/Secondary (0-12) 12 7. Father's Name (First, Middle, Last) Paul Yanowitz Da. Informant's Name/Relationship (7) Da. Method of Disposition 1 Burial 2 Cremation 3 Da. All Donation 5 Other (Specify 1. Signature of Funeral Service Licenses) 3a. Part 1. Enter the disease, or compshock, or heart failure. List high connections is ease or condition	Rd, #218  12. Was Decedent Even Armed Forces? 1   Yes 22   No If Yes, Give Year or Dates: ducation ide completed)  College (1-4or 5+)  Type. Print)  Daughter  I Removal from State y)  plications that caused the one cause on each line.	Silver  or in U.S. 13  16a. Der (Gi life  C  19b. Ma 1423  1423  20b. Place of Discemetery, co	Spring  10f. Zip  20  3. Was Decede If Yes, specification of work  Do NOT use  1 Lerical  illing Address ( 6  31 Arct position (Name ematory or of the moris  22. Name and  11800 N	D906  ent of Hispa fly Cuban, N  Coccupation c done durin e retired)  18.  (Street and tic Av e of ent place)  Address of New Ha	Mother's Na Bertha Number or F re, Roo FacilityHii	Jebrock Aural Route Num ckville, Date c 28, 20 nes-Rina re Ave,	USA 14. Rac Specify 16b. Kind of Bi  Depar e, Maiden Surnan ber, City or Town, MD 2085 20c. Location -	What Cou  e - Americk, White,  Wh usiness/Ir  Ctmen  State, Zi  City or T  ney,	1 □ Yes 2 Muntry?  rican Indian, , etc.  nite  ndustry  nt Store  ip Code)  Fown, State  MD  Home
Marital Status  1  Never Married 2  Married  3  Widowed 4  Divorced  15. Decedent's Ed. (Specify only highest grace  Elementary/Secondary (0-12)  12  7. Father's Name (First, Middle, Last)  Paul Yanowitz  Paul Sendroff/D  1  Burial 2  Cremation 3  4  Donation 5  Other (Specify  1. Signature of Funeral Service Licenses  3a. Part 1. Enter the disease, or compshock, or heart failure. List only compediate Cause (Final sease or condition)	12. Was Decedent Eve Armed Forces?  1	19b. Ma 1423 1423 20b. Place of Discemetery, co	a. Was Deceded If Yes, specific Yes, specif	ent of Hispa fy Cuban, N  No S  Occupation c done durin e retired)  18.  E (Street and e of e of Address of New Ha	Mother's Na Bertha Number or F re, Roo FacilityHii	Jebrock Aural Route Num ckville, Date c 28, 20 nes-Rina re Ave,	14. Rac Black Specify 16b. Kind of Bu  Depar e, Maiden Surnan ber, City or Town, 20c. Location- 20c. Location- 21di Fune	white, White, Who is in each of the control of the	nite ndustry  nt Store  Town, State  MD  Home
(Specify only highest grad  Elementary/Secondary (0-12)  12  The Father's Name (First, Middle, Last)  Paul Yanowitz  Paul Sendroff/D  Informant's Name/Relationship (7)  Paula Sendroff/D  Information 5 Other (Specify)	Type. Print)  Daughter  Removal from State y)  plications that caused the one cause on each line.	19b Ma 1423 1422 20b. Place of Discemetery, of	illing Address ( 6 31 Arct position (Name ematory or oth Memoria 22 Name and 11800 N	(done during retired)  18.  (Street and tic Ave of her place)  Address of Address of New Ha	Mother's Na Bertha Number or F re, Roo FacilityHii	Jebrock Gural Route Num ckville, Date c 28, 20 nes-Rina re Ave,	Depare, e, Maiden Surnande, ber, City or Town, MD 2085 20c. Location - 208 01r.	State, Zince State	ip Code) Town, State MD Home
Paul Yanowitz  Paul Sendroff/Da. Method of Disposition  1 Burial 2 Cremation 3 4 Donation 5 Other (Specify  1. Signature of Funeral Service Licens shock, or heart failure. List only commediate Cause (Final sease or condition	Type. Print)  Daughter  I Removal from State  y)  plications that caused the one cause on each line.	19b. Ma 1423 -422 20b. Place of Dis cemetery, c	iling Address (6 31 Arct position (Name ematory or of Memoris 22. Name and	(Street and tic Ave e of her place)  Al Grd Address of New Ha	Sertha Number or F re, Roo Ins Dec	Jebrock  Aural Route Num  ckville,  Date  c 28, 20  nes-Rina  re Ave,	ber, City or Town,  MD 2085 20c. Location  008 01r	State, Zi	Town, State  MD  Home
Paula Sendroff/D  a. Method of Disposition  1	Daughter  I Removal from State  y)  plications that caused the one cause on each line.  a.	20b. Place of Discemetery, co	31 Arct position (Name ematory or oth Memoria 22. Name and 11800 N	(Street and tic Av e of her place) al Grd I Address of New Ha	Number or F re. Roo lns Dec FacilityHii	ckville, Date  28, 20 nes-Rina re Ave,	MD 2085 20c. Location - 08 01r.	i3 City or T ney, era1	MD Home
a. Method of Disposition  1	Removal from State  y)  see  plications that caused the one cause on each line.  a.	20b. Place of Discemetery, co	31 Arct position (Name ematory or oth Memoria 22. Name and 11800 N	e of her place) al Grd Address of	ns Dec	ckville, Date  28, 20 nes-Rina re Ave,	MD 2085 20c. Location - 008 01r. 11di Fune	i3 City or T ney, era1	MD Home
I. Signature of Funeral Service Licens  3a. Part 1. Enter the disease, or compshock, or heart failure. List only comediate Cause (Final sease or condition	plications that caused thone cause on each line.	0	22. Name and 11800 N	I Address of New Ha	FacilityHi mpshi	nes-Rina re Ave,	ldi Fune	ral	Home
nmediate Cause (Final isease or condition	a Sepst								0,
equentially list conditions, any, bearing to inneclate ause. Enter Underlying ause (Disease or injury at initiated events sulting in death) Last	b. Perfor		Di	.ve>		eliti			Approximate Interval Betwee Onset and Deat
FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live birth 2	Fetal death							very Day Year
rt II. Other significant conditions co	contributing to death but a	not resulting in the	underlying ca	use given in	Part I.		_		
						auto _ per	opsy formed?	prior to co death?	topsy findings avai ompletion of cause 2  No
examiner? 1	28a. Date of Injury (Month, Day, )	28b. Time Injury	of 28	Other: 2 8c. Injury at Work? 1 ☐ Yes	I ☐ Nursing	Home 5 Res	sidence 6 Oth how injury occurr	red	_
9a. Certifier  (Check only one)  1 ☐ Certifying Phy 2 ☐ Medical Exam	<b>niner:</b> On the basis of e	xamination and/or	ath occurred a investigation,	at the time, o	date and place on, death occ	ce, and due to the	e cause(s) and mage, date and place,	anner as and due	stated. to the cause(s)
9b. Signature and title of certifier									
: 3I	FEMALE: b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  It II. Other significant conditions of the conditions	FEMALE: b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  It II. Other significant conditions contributing to death but in the past 12 months?  It II. Other significant conditions contributing to death but in the past 12 months in the past 13 months in the past 14 months in the past 15 months in the pas	Due to (or as a consequence of):    Due to (or as a consequence of):   Due to to the bast of pregnancy   Due to to the beath of pregnancy   Due to the beath of pregnancy   Due to to the beath of pregnancy   Due to the pregnancy   Due to the pregnancy   Due to the pregnancy   Due to the pregnancy	Due to (or as a consequence of):    Due to (or as a consequence of):   Due to (or as a consequence of pregnancy   Due to (or as a consequence of):   Due to (or as a consequence of to the past of pregnancy   Due to (or as a consequence of):   Due to (or as a consequence of the past of pregnate the past	Due to (or as a consequence of):    Due to (or as a consequence of):   Due to (or as a consequence of the consequen	Due to (or as a consequence of):  d	Due to (or as a consequence of):  d	Due to (or as a consequence of):  d.    Continue   Cont	Due to (or as a consequence of):  d.    Continue   Cont

DHMH 17 Rev 1/2001

Division of Vital Records, P.O. Box 68760,  $\circlearrowleft$ 

State of Maryland / Department of Health and Mental Hygien [ ] Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** December 21, 2008 8:30A Ling /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Silver Spring Montgomery Holy Cross Hospital Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 6. Sex 14 M 2 ☐ F 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Months Days Hours 86 Yrs. JAN. 16, 1922 China 213-40-9405 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a. State 10b. County the Medical Examiner must be notified at 1 ☐ Yes 2 🔯 No Silver Spring Directo Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with 20906 United States of America 13607 Athania St. or Items 23a Completed by Funeral death 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status illed within 72 hours after 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Asian 3 Widowed 4 XDivorced netural. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ent: If item 27 is marked other then ury or other treumatic event, the Ma Elementary/Secondary (0-12) College (1-4 or 5+) Business Owner Resturant 18 Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Unascertainable Unascertainable 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Jing W. Huang - Daughter 9229 Farnsworth Drive, Potomac MD 20854 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ▼Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Importent: If any injury or once. Ft. Lincoln Crematory 01/05/2009 Brentwood, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of FacilitySimple Tribute Funeral & Cremation 1040 Rockville Pike, Rockville, MD 20854 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Respiratory Failure Pnysician /Medical Due to (or as a consequence of): Examiner Recurrent Bilateral Pneumonia Sequentially list conditions, frag leading to many scause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner and I-transit law requires that the death certificate be executed Due to (or as a consequence of): attending physician a for use as the burial-Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal de: 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Year Month Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Congestive Heart Failure Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hypertension has 1 ☐ Yes 2 ☐ No 2 1 No 1 ☐ Yes Malnutrition 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 \(\subseteq\) Nursing Home 5 \(\subseteq\) Residence 6 \(\subseteq\)Other (Specify) 1 ☐ Yes 2 ☐ No 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Magner of Death 1 DNatural 28b. Time of al or Attending P safter death. I Director: Atter I d in by the funera After 1 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🔲 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospitel or Atte within 24 hours after de To the Funerel Direct completely filled in by the 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 268096 12/21/08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Road Silver Spring, MD 20910 Satyam A. Shah MD 22. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

9

	1- For State	ate of Maryland		it of Health are of Death	nd Mental		eg. No. 200	18 4318			
Physician/ Medical Examiner	Registrar 1. Decedent's Name (First, Middl Joseph	<sub>e,Last)</sub> Lee Werne	er		4	2. Date of Dear Month December	th	3. Time of Death 0232 hrs			
1	4a. Facility Name (if not institution Route 16 at Old Stage	-	er)	4b. City, Town, c	4b. City, Town, or Location of Death.  Hurlock  4c. County of Death  Dorchester						
Funeral	5. Social Security Number	6. Sex 7.	Age (In yrs. last birthda			4.0	th(MM/DD/YYYY) 9. Bi	ian i			
Director	219-70-7842	1 X M 2 F	48	Yrs. Months Da	ys Hours	Min. October	29, 1960 c	ountryMary1and			
ny	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or i	Location	cation 10d. Inside City Limits						
nd show a ce.	Maryland Car	coline	Dente	on				1 Yes 2 X No			
Maryland 28a-f sho d at once	10e. Street and Number			10f. Zip Code			0g. Citizen of What Cou				
ith the Maryland 23a or 28a-f show notified at once.	9280 Bloxom Roa	12. Was Decede	ent Ever in IIS 11	2162 3. Was Decedent of H				es of America			
r death with , or items 23 r must be no	1 Never Married 2 X M			If Yes, specify Cuba	an, Mexican, Pu	erto Rican, etc.)	White, etc.				
safter darral", or		vorced If Yes, Give Year or Dates:		1 Yes 2 X N			Specify: Cau				
hours and Exam	15. Decedent's Education (Spe Elementary/Secondary (0-12)		dur	cedent's Usual Occup ing most of working lit			16b. Kind of Business	al Facility			
5-0036 lied within 72 hour Hygiene. I other than "matu the Medical Exan	12			ministrato	r		Ecolog				
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shomatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	17. Father's Name (First, Middle					lame (First, Middle, Alice	Maiden Surname) Blockston				
2121 2121 Mental I Marked ic event,	Jesse Fi	Lfer Werne: ship (Type, Print)		Mailing Address (Stre	Mary eet and Number		mber, City or Town, Stat	te, Zip Code)			
imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after ment of Health and Mental Hygiene, trait: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner.  To Be Completed by	Laurie Werner	Wife		80 Bloxom			aryland 21	629			
Baltimore, ME permit. Pages 1 and 2 s Department of Health a Important: friem 27 injury or other traum.	20a, Method of Disposition  1 X Burial 2 Crematio	n 3 Removal from	State crematory	Disposition (Name of or other place)		Date	,				
Baltimore, permit. Pages I an Department of Hea Important: If iter injury or other tr.	4 Donation 5 Other S		Denton	Cemetery  22 Name and Addre		2/31/2008					
Ba perm Depa Impo	Handspill	house						yland 21629			
Physician /Medical	23a. Part I. Enter the disease, o failure. List only one cause		sed the death. Do not e	enter the mode of dyin	g, such as cardi	ac or respiratory an	rest, shock, or heart	Approximate Interval Between Onset and			
xaminer	Immediate Cause (Final disease or condition resulting in death)	a. Multiple Injuri			_			Death			
	Sequentially list conditions,	b									
niner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a co	onsequence of):		300		1.00	1			
nted d ansit	(Disease or injury that initiated events resulting in death) Last	Due to (or as a co	onsequence of):								
0, e be executed ysician and burial - transit	UNPENDED	AMENDED									
68760 certificate the ding physise as the but.	IF FEMALE: 23b. Was decedent pregnant in t		tcome of pregnancy	Fetal death 3	B Ectopic pr	egnancy	23d. Date of delive Month	ery Day Year			
b. Box 6876C the death certificate the attending physy the attending physoched for use as the b Physician/Me	past 12 months?	4 Pregnan	t at time of death 5	Other (Specify)							
cords, P.O. Box 6876( law requires that the death certificate has been signed by the attending phy 2.2 should be detached for use as the t npleted by Physician/M	Part II. Other significant condi	9OTKHOW		n the underlying cause	e given in Part I	. 23e. Did t	tobacco use contribute t	o the cause of death?			
P.O. res that the signed by be detacl							es 2 🗸 No 3 Pr	obably 4 Unknown			
ords v requi s been should						24a. Was auto	psy prior to	autopsy findings available ocompletion of cause of			
Records, The law requires ficate has been signage 2 should be Completed						1 🗸 Yes	ormed? death?				
of Vital Records, by Physician: The law requirement of the this certificate has been a meral director, page 2 should in: To Be Completed	25. Was case referred to medic examiner?	[Hospital:	patient 2 ER/Outp	26.Pla	Other N	neck only one)	Residence 6 V Oth	er: Scene			
of Viluing Physic After this funeral dir.	1 Yes 2 No 27. Manner of Death	28a Date of	Injury 28b. Tir	ne of Injury 28c. Ir	njury at Work?	28d. Describe	how injury occurred				
ion tendin leath. A the further the further attion		FOUND: Dec 28, 20	0203 h	nrs	Yes 2 V No		auto rolled over	<u> </u>			
Division o ital or Attending urs after death. ral Director: Aft lled in by the fune ertification:	3 Suicide 6 Cou	ild not be 28e. Place o	of Injury - At home, fam Local Street	n, street, factory, office	e building, etc.	or Town.		Rural Route Number, City			
C N in by	29a. Certifier	Physician: To the best of aminer: On the basis of	of my knowledge, death	occurred at the time,	date and place	, and due to the cau	use(s) and manner as st	ated.			
To the Ha within 24 To the Fa completed	one) 2 ✓ Medical Ex  29b. Signature and title of certif	and manner stat	examination and/or invited.		nse number	red at the time, date	29d. Date signed (A				
	Wordente O	he doule			C.M.E.		December 28,				
	30. Name and address of person Margarita Korell MD.	n who completed cause Assistant Medic		11 Penn Street,	Baltimore, I	MD 21201					
State	31. Date filed (Month, Day, Year	) 32. Regi	strar's Signature	1200							
Registrar	DEC 2 9	ZUUS I	OD!								
DHMH 17 Rev 1/2001			ORIC	SINAL			201	417			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** December 17. 2008 9:30 Anna Mae Willis Williams A /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Caroline Denton Caroline Home for Hospice If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Min. Months 1□ M 2□F Yrs Maryland 82 July 20. 1926 Director 221-16-9047 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location a or 28a-f show t be notified at 10a. State 10b. County 1 □Yes 2 No Director Maryland Caroline Denton 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number within 72 hours after death with or items 23a o aminer must be United States of America 21629 10729 Lewis Road by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. "natural", or item edical Examiner n 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No 1 ☐ Yes 2 No Specify. Specify: Caucasian 3 ☐ Widowed 4 ☐ Divorced d 2 should be filed within 72 hou th and Mental Hygiene. 7 Is marked other than "natura traumatic event, the Medical E: Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home/Farm Homemaker/Farm Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and 2 should be Mamie Ellen Schuyler Edward Howard Willis ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2::
Department of Health at Important: If item 27 Is any Injury or other trau 10729 Lewis Road, Denton, Maryland Peggy Willis Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/20/2008 Federalsburg, Maryland Concord Cemetery Name and Address of Facility Home, P.A. 12 South Second Street, Denton, Maryland 21629 23a: Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Colo-RECTAL CANIZA Metaitate 2 **Physician** 7-AV disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Due to (or as a conse mence of) cause. Enter Underlying Cause (Disease or injury Examiner certificate be executed burial-transi that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 No 4□Pregnant at time of death
9□Unknown 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ The law requires 1 ☐ Yes 2 No 3 Probably 4 Unknown this certificate has been si al director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1∐ Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Wother (Specify) OUSE Hospital: 2**\_\_\_\_\_1** 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 📋 Yes Certification: To 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? Hospital or Attending 5 Pending investigation 1 Natural after death.

I Director: Aid in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. To the

State Registrar

DEC

30. Name and address of per who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifie

32. Registrar's Signature 2008

316



Baltimore, Maryland 21215-0036

Box 68760.

P.0.

Division or Vital Records,

MAILTOND AVE

29c. License number

29d. Date signed (Month, Day, Year)

19/2001

122

Coldisaro MD

08-09699	
----------	--

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

eiores Diskane		- For State		ent of Health ar cate of Death	id Meritai n		200	8 4318
Physicia	an/	Registrar  1. Decedent's Name (First, Middle,Last)				2. Date of Death	2/24/2008	3. Time of Death 2221 hrs
edical Exami		Dolores Mae  4a. Facility Name (if not institution, give street and number)	Weibe	el L4b City Town o	r Location of Death	Month December 1	4c. County of Death	22211118
	н	Washington County Hospital	,017	Hagerstow	n .		Washington	
Funeral Director		5. Social Security Number 6. Sex 7. 211-24-3302 1 M 2 X F	Age (In yrs. last bi	rthday) If Under 1 Ye Months Da Yrs.			(MM/DD/YYYY) 9. Bird Foreig 26,1932 Co	
япу		Usual Residence of Decedent  10a. State 10b. County	10c. City, Tow	n or Location				10d. Inside City Limits
<b>*</b>	_	Maryland Washington	l l	gerstown				1 X Yes 2 No
Maryland 28a-f show d at once.	Director	10e. Street and Number		10f. Zip Code		109	g. Citizen of What Cour	ntry?
ith the 23a or notifie	al Di	920 Concord Stree 11. Marital Status 12. Was Deced	lent Ever in U.S.	2174		pecify Yes or No-	U.S.A.	can Indian, Black,
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiens in the Maryland Important. If item 71's marked other than "natural", or items 23a or 28a-f sho important. If item 71's marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at ance	, Funeral	1 Never Married 2 Married 1 Yes 3 X Widowed 4 Divorced If Yes, Give Year		If Yes, specify Cube	an, Mexican, Puerto	Rican, etc.)	White, etc.	
ours af atural xamin	eted by	15. Decedent's Education (Specify only highest grade		Decedent's Usual Occup	ation (Give kind of fe. DO NOT use ref	work done ired)	16b. Kind of Business/	ndustry
, MD 21215-0036 and 2 should be filed within 72 h the but and Memila Hygiene. (em 27 is marked other than "n traumatic event, the Medical E	omplete	Elementary/Secondary (0-12) College (1-4	or 5+)	Secretary		- 11	Synagogi	ı e
15-0 filed w I Hygid ed othe	ıoı	17. Father's Name (First, Middle, Last)	Di	skanet	18.Mother's Nam	e (First, Middle, M	eanette	Xander
D 21215-003 should be filed within and Mental Hygiene. T is marked other the natic event, the Med	To Be	Joseph Lazarus  19a. Informant's Name/Relationship (Type, Print )		9b. Mailing Address (Str	eet and Number or	Rural Route Numb	per, City or Town, State	e, Zip Code)
ore, MD ss 1 and 2 sho of Health and If item 27 is	8	Simone G. Heurich Da		13112 Bik		, Smith	sburg, Mo	
Baltimore, M permit Pages I and 2 Department of Health Important: If item 2 injury or other traun		20a. Method of Disposition  1 Burial 2 X Cremation 3 Removal from  4 Donation 5 Other Specify:	n State Hager	atory or other place)	ory 12			n, Maryland
Baltimo permit Pag Department Important: injury or ot	2	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	Inager	A2 Name and Addre	espon Feelityan		Home, Inc.	1, 1142, 241.0
Balt permit Departi Import	3. 3	R. Noel Brady, per DVR		40 East Ar	ntietam S	treet, H	agerstown,	
Physician /Medical		23a. Part I. Enter the disease, or complications that cau failure. List only one cause on each line.		not enter the mode of dyin	g, such as cardiac	or respiratory arre	st, snock, or neart	Approximate Interval Between Onset and Death
xaminer		Immediate Cause (Final disease or condition resulting in death)  a. Multiple Injury  Due to (or as a condition)						
	Į.	Sequentially list conditions, if any, leading to immediate b.  Due to (or as a condition)	onsequence of):					
	Examiner	cause. Enter Underlying Cause						-
uted uted nd ransit		events resulting in death) Last	consequence of):	007-14				
60, ate be executed hysician and te burial - transit	Medical	UNPENDED X AMENDED	2 per ME	DVR g887 1/1 g887 1/13/0	3/09 TT <b>)9 T</b> T			
3760, ficate be g physic s the bur	n/Me	23b. Was decedent pregnant in the	utcome of pregnant	cy Fetal death	3 Ectopic pregr	nancy	23d. Date of deliver Month	y Day Year
Box 6876  ne death certificate the attending physhed for use as the	Physician/	nast 12 months?	nt at time of death	5 Other (Specify)			l,	
that the dened by the	Phy	Part II. Other significant conditions contributing to		ting in the underlying caus	e given in Part I.	23e. Did to	bacco use contribute to	the cause of death?
rds, P.O.  v requires that the sbeen signed by the should be detached.	sd by					1 Yes		bably 4 Unknown
of Vital Records, ng Physician: The law requir ther this certificate has been s meral director, page 2 should I	Completed					24a. Was a autop perfor	sy prior to	utopsy findings available completion of cause of
tal Rec	Com			ac Di	ace of Death (Chec	1 ✔ Yes		es 2 No
Vital   hysician: this certifi	o Be	25. Was case referred to medical examiner?  1 ✓ Yes 2 No  Hospital: 1 tr	patient 2 🗸 ER		Othor		Residence 6 Othe	er:
ion of \ tending Phy eath. or: After the	⊢	27. Manner of Death 28a. Date of (Mgnth.,	f Injury 28	b. Time of Injury 28c. II	njury at Work?		now injury occurred estrian struck by	vehicle
Division tal or Attendi rs after death.	catic	2 Accident Investigation		e, farm, street, factory, offic	Yes 2 V No	28f. Location (S	Street and Number or R	ural Route Number, City
Divisi pital or Au ours after d neral Direct filled in by	Certification:	3 Suicide 6 Could not be	Local Street	, iaim, succe, lactory, one	o ponding, etc.	or Town, S		
Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Furnarial Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be deached for use as the burial - transi	Medical C	29a. Certifier 1 Certifying Physician: To the best one) 2 Medical Examiner: On the basis of	fexamination and/	death occurred at the time or investigation, in my opin	, date and place, ar ion, death occurred	nd due to the caus	e(s) and manner as sta and place, and due to t	ited. he cause(s)
To To corr	Mec	and manner st	ate0.	29c. Lice	ense number	OCME	29d. Date signed (M	
		Theodore M. King J.	My mis		C.M.E.		December 25, 2	.008 
1		30. Name and address of person who completed caus Theodore M. King, Jr., MD. Assista	e of death (Item 23 nt Medical Exa		Street, Baltimo	ore, MD 21201		
<u>u</u>	State	31. Date filed (Month, Day Year) 2 22. Re	/	b. fares				
Regi	strar	THUE TO 2000 1	Charles 1					

			. For			nd / Depa	artment of I	Health a	re All Copie and Mental H		gible.	
			State Registrar			Ce	rtificate of	Death		Reg. No. 2	008	43184
	Physicia /Medic		Decedent's Name (First, Middle REGINA ELIZ		ZELLNER				2. Date of Decem	Death Day 1ber 20,	, 2008	3. Time of Death
	Examin		4a. Facility Name (If not institution FREDERICK MEI	_			4b. City, Town, o		f Death	1	inty of Death REDERIC	K
Ī	Funeral Director		5. Social Security Number 050-07-3953	6. Sex 1 □ M 2 🛣 F	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days		Min. 8. Date of E (Month,	Day, Year)	Coun	lace (State or Foreign try) V York
			Usual Residence of Decedent  10a. State 10b. County			ty, Town or Lo	cation		1200			0d. Inside City Limits
	ours after death with the Marylan ral", or items 23a or 28a-f show Evanin remast	Director	Maryland Mont	gomery		Clark	sburg 10f. Zip Code			10g. Citizen	of What Coun	1 ☐ Yes 2 ☒ No
1	3a or		12824 Clarksbu	irg Square	e Road.	Unit40		1		Uni	ted STa	ates
7	death ms 2	Funeral	11. Marital Status		edent Ever in U				in? (Specify Yes or I Puerto Rican, etc.)	1	Race - Americ	an Indian,
	72 hours after death with the Maryland inatural", or items 23a or 28a-f show diest Evaniner nust be molified at	þ	1 ☐ Never Married 2 ☐ Mar 3 🕱 Widowed 4 ☐ Divorced	ried 1 □Yes	2 X No ive		1 □Yes 2.2XINo		ruerto nicari, etc.)		Black, White, e ec <i>ify:</i> Wh	ite
	in 72 hours n "natural"; n Jical Exe	Completed	(Specify only highe	nt's Education st grade completed		16a. Dece (Give life.	dent's Usual Occu kind of work done DO NOT use retire	ipation during most ( ed)	of working	16b. Kind o	f Business/Inc	iustry
1	ed with ygiene ier thai		Elementary/Secondary (0-12)		1-4or 5+)	Во	okkeeper	T		Food		
	permit. Pages 1 and 2 should be tiled within 72 in Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natul any Injury or other traumatic event, In Medical once.	To Be	17. Father's Name (First, Middle, George Neare)	,				Eli	's Nam <i>e (Fir</i> st, <i>Mida</i> zabeth Kei	nnedv	,	
	shou and N s mar	_	19a. Informant's Name/Relations	hip (Type. Print)		19b. Maili	ng Address (Stree	t and Number	r or Rural Route Nun	nber, City or To	wn, State, Zip	Code)
,	and 2 ealth n 27 I		Elizabeth Forre	est / Daug		12824	Clarksb	urg Sq	uare Road	, Unit	<u>406 Mar</u>	yland 2087
	ges 1 nt of H if Itel or otl		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation	3 ☐ Removal from	State		sition (Name of matory or other pla	L	Date December		on - City or To	
	iff. Pa intmer intant: injury		4 □ Donation 5 □ Other (S		Fre		Cremato		22, 2008 Stauffer	Frede	rick,	Maryland
1	Deparent Important Important Insportant Insp		21. Signature of Pulleral Service	224								and 21771
	hysician /Medical		23a. Part1. Enter the disease, shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	_a G(		ntesti	er the mode of dy		cardiac or respiratory			Approximate Interval Between Onset and Death
É	Examiner	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b	(or as a conseq							
	earn cernificate be executed attending physician and for use as the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	(or as a conseq	uence of):						
, .	uncate by g physici as the bu	ledical		d								
of the or	Attending Prysician: The law requires that the deain certificate refer, After this certificate has been signed by the attending physiby the funeral director, page 2 should be detached for use as the l	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	1 Live	itcome of pregnation 2 ☐ Feta gnant at time of a nown	al death 3[	☐ Ectopic pregnan ☐ Other (specify) _	ісу		23d.	Date of delive Month	ery Day Year
iron that	ires that the de signed by the a d be detached f	þ	Part II. Other significant conditi	ons contributing to o	death but not res	ulting in the u	nderlying cause gi	iven in Part I.				e cause of death?
	as been s 2 should	Completed	Ventral he	rnia					24a. Wa			osy findings available npletion of cause of
Ę.	aing Proysician: The h. After this certificate h. funeral director, page	Com							pe 1 🗆 Yes	normed?	death?	2 No
dolo	sician certifi irector	) Be	25. Was case referred to medica examiner?	Hospital:	lanationt OF	1 FD/O. to -4:-	ot ot	her:	of Death (Check only		0	
40	grny erthis eral d	n: To	27. Manner of Death	28a. Date		28b. Time o	IL 3 L DOA	4 LI Nur	sing Home 5 ☐ Re 28d. Describ	e how injury oc		)
dipudi	death. ctor: Aft y the fun	Certification:	1 Natural 5 Pendir 2 Accident investi 3 Suicide 6 Could	gation not be		Injury ome, farm, sti		Yes 2□N		(Street and Nu	umber or Bura	l Route Number,
	s after al Director	Certi	4 ☐ Homicide determ	build	ling, etc. (Speci	fy)	, <b>,</b> ,		City or T	own, State)		
in a land	o the hospital of Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fur	Medical		Examiner: On the					d place, and due to to th occurred at the time			
i d	Vithi Com	Ž	29b. Signature and title of certifie	0 1 1127	ا میلید			15e number 2064	741		gned (Month, I	
	10		30. Name and address of serson	who completed cau	ise of death (Iter	n 23a) (Type.	Print)		1-11	10	100/	2008 Nanyland
	( )		Misty Leigh	n Willia	MS	Frede	rick M	embric	ed Hospit	al Fre	edenik	Maryland
	Sta	te	31. Date filed (Month, Day, Year)	32.	Registrar's Signe	ature 9 9	2000		10	M.		

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Maryland		artment of F		-	giene Reg. <b>N2</b> 0 0 8	43185
	Physici /Medi	al	1. Decedent's Name (First, Middle, Las  MARY  4a. Facility Name (If not institution, give	ie ALMOI	ND	Ab. City Tourn	r Location of Dea	2. Date of Dea Month	Day Year	7 1555 M
	Examir Funeral Director	ier	Albeghang Cty R 5. Social Security Number 6. Se	URSING & KE	EhAb last birthday) Yrs.	If Under 1 Year Months Days	DERLAI If Under 24 Hr. Hours Min	s. 8. Date of Birt	Ahkeghi	
	e Maryland	ctor	Usual Residence of Decedent  10a. State 10b. County  MD ALLE 9		On L	ocation ERLA	שט			10d. Inside City Limits
	th with th 23a or 28 ust be no	al Director	10e. Street and Number 730 Furnace Stre	et		10f. Zip Code	21502		10g. Citizen of What C	Country?
980	72 hours after death with the Maryland natural', or Items 23a or 28a-f show Jisal Exeminer fourt be motified at	by Funeral	11. Marital Status 1 ☐ Never Married 2万 Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S Amed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 🞢 No	lispanic Origin? ( an, Mexican, Pue Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - Am Black, Wh Specify: (	
21215-0036	within ane. than "	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0·12) 1 2		(Give life.	dent's Usual Occup kind of work done DO NOT use retired omemaker	during most of wo	orking	16b. Kind of Business	s/Industry
Maryland 2	d 2 should be filed th and Mental Hygion 7 Is marked othar traumatic event, It	To Be C	17. Father's Name (First, Middle, Last)  Carl Perdew  19a. Informant's Name/Relationship (T	ing Bright	10b Mailt	Address (Street	Cora	Jane Stu		7-0-4
	1 and 2 Health a am 27 Is thar tra		Sheila Stonesiefe  20a. Method of Disposition	er/daughter	1870	)4 Willian	ms Road		stone, MD	21530
Baltimore,	permit. Pages Department of Important: If it any injury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify, 21. Signature of Euneral Service License)	21A	TE HI	matory or other place NATAMY L Name and Addre	DFO 12		Baltimore	Street
	Priysician /Medical Examiner	ılner	shock or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	lications that caused the death one cause on each line.  a. Due to (or as a consequence)  Due to (or as a consequence)	uence of);	altimore, er the mode of dyin	g, such as cardia	ic or respiratory ar	28	Approximate Interval Between Onset and Death
. Box 68760,	odeath certificate be executed the attending physician and ed for use as the burial-transit	Physician/Medical Examine	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \to Yes 2 \to No	d	ncy death 3	Ectopic pregnancy	,		23d. Date of de Month	livery Day Year
ds, P.O.	w requires that the de s been signed by the a should be detached to	by	9 ☐ Unknown Part II. Other significant conditions co		ulting in the u	nderlying cause give	en in Part I.		bacco use contribute t	o the cause of death?
Vital Records,	The la ate has page 2	Completed						24a. Was a autop perfor	sy prior to death?	utopsy findings available completion of cause of
Vita	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	Hospital:		Othe	00	ath (Check only or		
-	inding Physath. rr: After this re funeral di	<del> </del>	1 Yes 2 No  27 Manner of Death 1 Natural 5 Pending 2 Accident investigation		ER/Outpatien 28b. Time of Injury	28c. Injun	4 Nursing	N-	ence 6 □Other (Spe ow injury occurred	ecify)
Division	To tha Hospital or Attanding Ph within 24 hours atter death. To tha Funeral Diractor: After th completely filled in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At hor building, etc. (Specily,	·) 			City or Tow		
	tha Hosp iin 24 hou tha Fune. ipletely fil	ledical	one) 2 Medical Exam	rsician: To the best of my know iner: On the basis of examinati and manner stated.	wledge, death ion and/or in	vestigation, in my or	pinion, death occ	urred at the time, o	tate and place, and du	e to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	J. Barrer	0	29c. License	1486:		29d. Date signed (Moni	th, Day, Year)
			30. Name and address of person who con Robustiano Bar	,		Print) Nursing&l		Cumblan	d.MD 21502	2
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signat					,	

#### Plea

Please Type or Print in Bla	nck Indelible Ink. Ensure A	II Copies Are Legible.	
For State of Maryland	Department of Health and N Certificate of Death	Mental Hygiene 2008	43186
1. Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
Nina Mae Chappell Barne	es	December 17, 2008	2:10 P. M

Physician /Medical **Examiner** 

1 - For State Registrar

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Mudical Evantinar must be confired at once.

Baltimore, Maryland 21215-0036

**Physician** /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

er	Larkin (	mac N	enavii.									Cannaa	
	Nursin 5. Social Security No	ig Cent	er 6. Sex		je (In yrs. las		Bow i		rs. 8 Date of I			Georges  Birthplace (State or Fo	
	246-36-8	3227	1 ☐ M 2 ☐		83	Yrs.	Months Days			Birth Day, Year <b>19</b> er 17,		Country)  orth Carol:	
	Usual Residence of	Decedent 10b. County			100 City	Town or Lo	action					10d. Inside City L	
'n	10a. State		e Georg	<b>200</b>	,	Bowie	cation				1X Yes 2		
Director	Maryland  10e. Street and Num		e Geory	ges		DOMTE	10f. Zip Code		10a Citize	0g. Citizen of What Country?			
			ce Drive	Δ.			20721				United States		
era	11. Marital Status	LS Lak		s Decedent B	Ever in U.S.	13. \							
Funeral	1 ☐ Never Marrie	ed 2□ Marr	ried Arm	ned Forces?  Yes 2 👿 N			If Yes, specify Cuban, Mexican, Puerto Rican, etc.)					Black, White, etc.	
þ	3 X Widowed 4 □ Divorced If Yes, Give Year or Dates:						I∐Yes 2 <b>1</b> No	Specify:	Si	pecify:	Black		
Completed	(Specify only highest grade completed) (G						dent's Usual Occi	e during most of	working	16b. Kind	of Busines	ss/Industry	
du	Elementary/Secon	Elementary/Secondary (0-12) College (1-4or 5+) Homemaker							Domestic				
								Name (First Midd			.10		
Be		Father's Name (First, Middle, Lest)  Jeremiah Chappell  Bessie							e Nell	Watso			
၉	19a. Informant's Na				to=1	19h Mailin	n Address (Stree		Rural Route Nur	- 17		Zin Code)	
7.7	Dorothy			•	LEL				e; Bowie	•		•	
H	20a. Method of Disp		, <u>,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,</u>	13011	20b. Pla		sition (Name of natory or other pl			-		or Town, State	
	1 <b>X</b> Burial 2 ☐ 4 ☐ Donation			from State			natory or other pi morial G		. 2 <sup>Date</sup> , 2008		Nort	h Carolina	
	21. Signature of Fu	-		11	SEI	22	Name and Add	ress of Facility					
	Ra	adall.	1 BC	tolla	57	R	. N. Hoi	rton Com	pany Mor	tician	s, In	D.C. 200	
$\dashv$	23a, Part 1, Enter th	ne disease, or	complications	that caused	d the death.						пусоп	Approximate	
	shock, or heart failure. List only one cause on end, line.  Interval Betwee Onset and Deat												
	shock, or heart failure. List only one cause on eact, line.  Interval Between Onset and Death Onset and Death												
	Immediate Cause (Final disease or condition Cauching Cause)												
	Immediate Cause ( disease or condition resulting in death)	Final	a	ue to (or es	edic	-	Arry H	mia					
	disease or condition resulting in death)	Final n	a	(a	edic	-	Arry H	mia					
ner	disease or condition resulting in death)  Sequentially list confirming to improve the conditions of th	Final n nditions, mediate	a	(a	a conseque	ence of):	Arry H	mia					
miner	disease or condition resulting in death)  Sequentially list conference in the cause. Enter Under Cause (Disease or Cause (Disease (Disease or Cause (Disease or Cause (Disease	Final nditions, mediate raying injury	a	ue to (or es	a conseque	ence of):	Arry H	mia					
Examiner	disease or condition resulting in death)  Sequentially list confidence in the condition of	Final n ditions, mediate riying injury	ab	ue to (or es	a conseque	ence of):	Arry H	mia					
al Examiner	disease or condition resulting in death)  Sequentially list condition if env, leading to immicause. Enter Under Cause (Disease or that initiated events	Final n ditions, mediate riying injury	ab	due to (or es	a conseque	ence of):	Amy H	mia					
	disease or condition resulting in death)  Sequentially list condition if env, leading to immicause. Enter Under Cause (Disease or that initiated events	Final n ditions, mediate riying injury	ab	due to (or es	a conseque	ence of):	Arry H	mia					
	disease or condition resulting in death)  Sequentially list condition if env, leading to improve the cause. Enter under Cause (Disease or that initiated events resulting in death) L  IF FEMALE:	Final n ditions, mediate ryving injury	a	due to (or es	a conseque a conseque	ence of):	Arry H	mia		233	d Date of r	falivery	
	disease or condition resulting in death)  Sequentially list conif env. leading to immoduse. Enter under Cause (Disease or that initiated events resulting in death) L  IF FEMALE: 23b. Was decedent in the past 12	Final n n n n n n n n n n n n n n n n n n	a	uue to (or as uue to (or as uue to (or as uue to (or as	a conseque a conseque a conseque	ence of): ence of): ence of): ence of):	□ Ectopic pregnar	псу		230	d. Date of o	delivery Day Yea	
	disease or condition resulting in death)  Sequentially list conference if env. leading to improve cause. Enter under Cause (Disease or that initiated events resulting in death) L  IF FEMALE: 23b. Was decedent	Final n n n n n n n n n n n n n n n n n n	a	Due to (or as	a conseque a conseque a conseque	ence of): ence of): ence of): ence of):	l	псу		. 23(			
/ Physician/Medical Examiner	disease or condition resulting in death)  Sequentially list conif env, leading to import cause. Enter under Cause (Disease or that initiated events resulting in death) L  IF FEMALE: 23b. Was decedent in the past 12 1 □Yes 2	Final n n n n n n n n n n n n n n n n n n	a	oue to (or as	a conseque a conseque a conseque of pregnan 2 Fetal cat time of de	ence of): ence of): ence of): ecy death 3 [ eath 5 [	□ Ectopic pregnar □ Other (specify)	ncy	23e. Di	-	Month		
by Physician/Medical	disease or condition resulting in death)  Sequentially list conif env. leading to immoduse. Enter under Cause (Disease or that initiated events resulting in death) L  IF FEMALE: 23b. Was decedent in the past 12 1	Final n ditions, mediate rying injuryast	a	oue to (or as	a conseque a conseque a conseque of pregnan 2 Fetal cat time of de	ence of): ence of): ence of): ecy death 3 [ eath 5 [	□ Ectopic pregnar □ Other (specify)	ncy		d tobacco use	Month contribute	Day Yea	
by Physician/Medical	disease or condition resulting in death)  Sequentially list conif env. leading to immoduse. Enter under Cause (Disease or that initiated events resulting in death) L  IF FEMALE: 23b. Was decedent in the past 12 1	Final n n n n n n n n n n n n n n n n n n	a	oue to (or as	a conseque a conseque a conseque of pregnan 2 Fetal cat time of de	ence of): ence of): ence of): ecy death 3 [ eath 5 [	□ Ectopic pregnar □ Other (specify)	ncy	1(	d tobacco use	Month contribute No 3□	Day Year to the cause of death Probably 4▼ Unkn	
by Physician/Medical	disease or condition resulting in death)  Sequentially list conif env. leading to immoduse. Enter under Cause (Disease or that initiated events resulting in death) L  IF FEMALE: 23b. Was decedent in the past 12 1	Final n ditions, mediate rying injuryast	a	oue to (or as	a conseque a conseque a conseque of pregnan 2 Fetal cat time of de	ence of): ence of): ence of): ecy death 3 [ eath 5 [	□ Ectopic pregnar □ Other (specify)	ncy	1 [	d tobacco use	Month contribute No 3  24b. Were	Day Year to the cause of death Probably 4 X Unkn autopsy findings ava- to completion of caus	
y Physician/Medical	disease or condition resulting in death)  Sequentially list conif env. leading to immoduse. Enter under Cause (Disease or that initiated events resulting in death) L  IF FEMALE: 23b. Was decedent in the past 12 1	Final n ditions, mediate rying injuryast	a	oue to (or as	a conseque a conseque a conseque of pregnan 2 Fetal cat time of de	ence of): ence of): ence of): ecy death 3 [ eath 5 [	□ Ectopic pregnar □ Other (specify)	ncy	1[	d tobacco use  ☐ Yes 2 ☐  as an	Month  contribute  No 3   24b. Were prior to death	Day Year to the cause of death Probably 4 X Unkn autopsy findings ava- to completion of caus	
by Physician/Medical	disease or condition resulting in death)  Sequentially list conif env. leading to immoduse. Enter under Cause (Disease or that initiated events resulting in death) L  IF FEMALE: 23b. Was decedent in the past 12 1	red to medical	a. Do b. Do c	oue to (or as	a conseque a conseque a conseque cof pregnan 2 Fetal cat time of de	ence of): ence of): ence of): ency death 3 [ eath 5 [ ting in the un	Ectopic pregnal Other (specify)	ncy iven in Part I. 26. Place of	1[1	d tobacco use  Yes 2   as an  topsy rformed? s 2 X No y one)	Month contribute No 3   24b. Were prior to death 1   Y	Day Year  to the cause of death  Probably 4 T Unking  autopsy findings ava to completion of caus  es 2 □ No	
Be Completed by Physician/Medical	disease or condition resulting in death)  Sequentially list conif env. leading to immoduse. Enter under Cause (Disease or that initiated events resulting in death) L  IF FEMALE: 23b. Was decedent in the past 12 1	Final n ditions, mediate riving linjury Last pregnant months?  No cicant condition line line line line line line line lin	a. Do	Due to (or as Du	a conseque	ence of): ence of): ence of): ence of): ting in the un	Ectopic pregnal Other (specify)  nderlying cause g	iven in Part I.  26. Place of ther:	24a. W au pe 1   Ye Death (Check onl)	d tobacco use  Yes 2  as an topsy unformed? s 2 M No y one) ssidence 6	Month contribute No 3  24b. Were prior to death 1  The contribute of the contribute	Day Year  to the cause of death  Probably 4 T Unking  autopsy findings ava to completion of caus  es 2 □ No	
Be Completed by Physician/Medical	disease or condition resulting in death)  Sequentially list conifers, leading to implement the cause. Enter under Cause (Disease or that initiated events resulting in death) L  IF FEMALE: 23b. Was decedent in the past 12 1	Final n ditions, mediate rying injuryast t pregnant months? No cicant condition	a. Do b. Do c d  23c. If ye 4	Due to (or as Du	a conseque a conseque a conseque a conseque cons	ence of): ence of): ence of): ency death 3 [ eath 5 [ ting in the un	Ectopic pregnal Other (specify)  nderlying cause g	26. Place of ther: 4 🛣 Nursin	24a. W au pe 1   Ye Death (Check onl)	d tobacco use  Yes 2   as an  topsy rformed? s 2 X No y one)	Month contribute No 3  24b. Were prior to death 1  The contribute of the contribute	Day Year  to the cause of death  Probably 4 T Unking  autopsy findings ava to completion of caus  es 2 □ No	
Be Completed by Physician/Medical	disease or condition resulting in death)  Sequentially list conifers, leading to immoduse. Enter under Cause (Disease or that initiated events resulting in death) L  IF FEMALE: 23b. Was decedent in the past 12 1	Final n  Inditions, mediate ryung injury Last  It pregnant months?  INO  Icant condition  Inditions, mediate ryung injury  Inditions, mediate red to medical	a. Do b. Do c  23c. If ye 4	es, outcome Live birth Pregnant a Unknown  I lnpatie	a conseque	ence of): ence of): ence of): ence of): ting in the ur ence of):  ER/Outpatier 28b. Time of Injury	□ Ectopic pregnar □ Other (specify)  Inderlying cause go  Int 3 □ DOA Or Section 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	26. Place of ther: 4 🋣 Nursinury at ork?	24a. W au pe 1   Ye Death (Check onl g Home 5   Re 28d. Describ	d tobacco use  Yes 2  as an topsy from ed? s 2 \( \) No y one) esidence 6 [ be how injury of	Month  e contribute  No 3   24b. Were price at 1   Y  Other (Specurred	Day Year  b to the cause of death  Probably 4 ▼ Unknown  autopsy findings avaito completion of cause  es 2 □ No  pecify)	
Be Completed by Physician/Medical	disease or condition resulting in death)  Sequentially list conifers, leading to implement the cause. Enter under Cause (Disease or that initiated events resulting in death) L  IF FEMALE: 23b. Was decedent in the past 12 1	Final n ditions, mediate rying injuryast t pregnant months? No cicant condition	a. Do b. Do c	es, outcome Live birth Pregnant a Unknown  In Inpatie Date of Inju	a conseque	ence of): ence of): ence of): ence of): ence of): ting in the unce of): ence	Ectopic pregnal Other (specify)  nderlying cause g	26. Place of ther: 4 🋣 Nursinury at ork?	24a. W au pe 1   Pe   Death (Check onling Home 5   Rd   28d. Describ	d tobacco use  Yes 2  as an topsy from ed? s 2 \( \) No y one) esidence 6 [ be how injury of	Month  e contribute  No 3   24b. Were price at 1   Y  Other (Specurred	Day Year  to the cause of death  Probably 4 T Unking  autopsy findings ava to completion of caus  es 2 □ No	
Certification: To Be Completed by Physician/Medical	disease or condition resulting in death)  Sequentially list conif env. leading to immoduse. Enter under Cause (Disease or that initiated events resulting in death) L  IF FEMALE: 23b. Was decedent in the past 12 1   Yes 2 2 9   Unknown  Part II. Other signiff  FCU    25. Was case reference examiner? 1   Yes 2 X    27. Manner of Deatt   X   27. Manner of Deatt   Accident   3   Suicide   4   Homicide	Final n  Inditions, mediate riving ginjury Last  It pregnant months?  No  Inditions, mediate riving ginjury Last  It pregnant months?  No  Inditions, mediate riving ginjury Last  Inditions ginjury L	a. Do b. Do c	Due to (or as the to (or as th	a conseque	ence of): ence of): ence of): ence of): ence of): ting in the ur ence of): e	Ectopic pregnal Other (specify)  Int 3 DOA  The specify of the specific of the	26. Place of ther: 4 🛣 Nursinury at ork?	24a. W au pe 1   Pe	d tobacco use  Yes 2  as an Itopsy unformed?  S 2 N No  yone)  esidence 6 [  be how injury of the fown, State)	Month  contribute  No 3   24b. Were prior 1  death 1  Y	Day Year  to the cause of death  Probably 4 ▼ Unkn  autopsy findings ava to completion of caus  es 2 □ No  Pecify)  Rural Route Number	
Certification: To Be Completed by Physician/Medical	disease or condition resulting in death)  Sequentially list conifers, leading to immoduse. Enter under Cause (Disease or that initiated events resulting in death) L  IF FEMALE: 23b. Was decedent in the past 12 1	Final n  Inditions, mediate rying injury	a. Do b. Do d. C. Do d	Due to (or as Du	a conseque	ence of): ence o	Ectopic pregnal Other (specify)  Inderlying cause go  Int 3 □ DOA Of 28c. Inj  M 1 1  Beet, factory, office In occurred at the	26. Place of ther: 4 🛣 Nursinury at ork?	24a. Wau pe 1   Yes   Death (Check onling Home 5   Re   28d. Describe   28f. Location City or select	d tobacco use  Yes 2   as an topsy informed? s 2 M No y one) esidence 6 [ be how injury of the couse(s) a	Month  contribute  No 3   24b. Were prior 1  death 1	Day Year  to the cause of death  Probably 4 ▼ Unkn  autopsy findings ava to completion of caus  es 2 □ No  Pecify)  Rural Route Number	
Certification: To Be Completed by Physician/Medical	disease or condition resulting in death)  Sequentially list conifers, leading to immoduse. Enter under Cause (Disease or that initiated events resulting in death) L  IF FEMALE: 23b. Was decedent in the past 12 1 1 Yes 2 9 Unknown  Part II. Other signifers of Death 12 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only one)	Final n  Inditions, mediate rying ginjury Last  It pregnant months?  No  Icant condition  I	a. Do b. Do c  23c. If ye  4	pue to (or es  pue to (or as  pue to (or as)  pue to (or as  pue to (or as  pue to (or as)  pue to (or	a conseque	ence of): ence o	Ectopic pregnand Other (specify)  Inderlying cause go a second of the se	26. Place of ther: 4 🗶 Nursin ury at ork?	24a. Wau pe 1   Yes   Death (Check onling Home 5   Re   28d. Describe   28f. Location City or select	d tobacco use  Yes 2   as an topsy informed?  s 2 M No  y one)  esidence 6 [ be how injury on  n (Street and I  Town, State)  the cause(s) a  ne, date and p	Month  c contribute  No 3   24b. Were prior 1  death 1	Day Year  to the cause of death  Probably 4 \( \mathbb{Y} \) Unkn  autopsy findings ava- to completion of caus?  es 2 \( \subseteq No  \)  Probably 4 \( \mathbb{Y} \) Unkn  autopsy findings ava- to completion of caus?  es 2 \( \subseteq No  \)  Probably 4 \( \mathbb{Y} \) Unkn  autopsy findings ava- to completion of cause  autopsy findings av	
Be Completed by Physician/Medical	disease or condition resulting in death)  Sequentially list conifers, leading to immoduse. Enter under Cause (Disease or that initiated events resulting in death) L  IF FEMALE: 23b. Was decedent in the past 12 1	Final n  Inditions, mediate rying ginjury Last  It pregnant months?  No  Icant condition  I	a. Do b. Do c  23c. If ye  4	Due to (or as Du	a conseque	ence of): ence o	Ectopic pregnal Other (specify)  Inderlying cause grant 3 DOA of 28c. Injury M 11  eet, factory, office the occurred at the vestigation, in my 29c. Licer	26. Place of ther: 4 🛣 Nursinury at ork?  Yes 2 No time, date and py opinion, death of the number	24a. Wau pe 1   Yes   Death (Check online   28d. Describe   28f. Location   28f. Location   City or   lace, and due to to cocurred at the time	d tobacco use  Yes 2  as an itopsy informed?  s 2 M No  y one)  esidence 6 [  be how injury of the cause(s) are, date and p  29d. Date s	Month  contribute  No 3   24b. Were prior 1  death 1  Y  Other (S) occurred  Number or   Indiana manner lace, and dissigned (Month)	Day Year  Probably 4 ▼ Unkn autopsy findings ava to completion of caus? es 2 □ No  Pecify)  Rural Route Number, as stated. tue to the cause(s)	
Certification: To Be Completed by Physician/Medical	disease or condition resulting in death)  Sequentially list conif env. leading to immoduse. Enter under Cause (Disease or that initiated events resulting in death) L  IF FEMALE: 23b. Was decedent in the past 12 1	Final n  Inditions, mediate riving ginjury Last  It pregnant months?  No  Inditions, mediate riving ginjury Last  It pregnant months?  No  Inditions ginjury Last  Inditions g	a. Do b. Do c	es, outcome Live birth Pregnant a Unknown  In patient  To the best in the basis of d manner sta	a conseque	ence of): ence o	Ectopic pregnal Other (specify)  Int 3 DOA   The specify of the specific of th	26. Place of ther: 4 🛣 Nursin ury at ork?  Yes 2 No time, date and propinion, death of the content of the cont	24a. W au p Per	d tobacco use  Yes 2  as an	Month  contribute  No 3   24b. Were prior 1  death 1	Day Year  to the cause of death  Probably 4 \( \mathbb{Y} \) Unkn  autopsy findings ava- to completion of caus?  es 2 \( \subseteq No  \)  Probably 4 \( \mathbb{Y} \) Unkn  autopsy findings ava- to completion of caus?  es 2 \( \subseteq No  \)  Probably 4 \( \mathbb{Y} \) Unkn  autopsy findings ava- to completion of cause  autopsy findings av	
Certification: To Be Completed by Physician/Medical	disease or condition resulting in death)  Sequentially list conifers, leading to immoduse. Enter under Cause (Disease or that initiated events resulting in death) L  IF FEMALE: 23b. Was decedent in the past 12 1 1 Yes 2 9 Unknown  Part II. Other signifers of Death 12 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only one)	Final n  Inditions, mediate rying injury	a. Do b. Do c	es, outcome Live birth Pregnant a Unknown  1 □ Inpatie Date of Inju (Month, Da)  To the best In the basis of d manner sta	a conseque	ence of): ence o	Ectopic pregnal Other (specify)  Inderlying cause g  Int 3 DOA O  Int	26. Place of ther: 4 🛣 Nursin ury at ork?  Yes 2 No time, date and propinion, death of the content of the cont	24a. Wau pu	d tobacco use  Yes 2  as an	Month  c contribute  No 3   24b. Were prior 1  death 1    Other (S)  cocurred  Number or   and manner lace, and d  signed (Mo	Day Year  Probably 4 ▼ Unkn autopsy findings ava to completion of caus? es 2 □ No  Pecify)  Rural Route Number, as stated. tue to the cause(s)	

State of Maryland / Department of Health and Mental Hygiene 0 0 8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 16 PM DECEMBER 22 Mary Jane Birmingham 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE HOSPITAL AGNES Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day) 9. Birthplace (State or Foreign 6. Sex 5. Social Security Number (In yrs. last birthday) **Funeral** Months Days 1 □ M 2 🔀 F 12/19/ 1942 Chicago, 220-42-7812 **Director** Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 and 2 should be filed within 72 hours after death with the Marylan Health and Mental Hygiene. tem 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Wedical Examinat must be notified at MD Baltimore Towson, Maryland 1 □Xes 2 □ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21204 USA 520 Park Avenue by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married Specify: White Maryland 21215-0036 White 1 ☐ Yes 2 ☐ XNo Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Disable Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Janet Keen Hudson Grant Birmingham 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 520 Park Avenue Towson, Maryland 21204 Department of Health a Importent: If item 27 Is any Injury or other tra once. Anne Hanseth (Sister) Saltimore. 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Howard Univ School 12/26/08 Washington, D C 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 3821 14th Street N W 21. Signature of Funeral Service Licenses Washington, D C 20011 Terry A. Austri Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one hause on each line. Immediate Cause (Final FULMINANT DIFFUSE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): SYNDROME Examiner ABDOMEN COMPARTMENT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed PROFOUND METABOLIC attending physician and for use as the burial-tran Due to (or as a consequence of): RENAL FAILURE CUTE Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, CELL LUNG CARCINOMA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed UBSTRUCTIVE PULMONARY 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has page 2 s autopsy performed? After this certificate funeral director, pag Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Pres 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? To the Hospital or Attending within 24 hours after death. To the Funeral Director: After 1 PNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Funeral Director: , completely filled in by the f 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie KESIDENT 23766 DECEMBER 22, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE, MD 21229 900 AVE, JINCY CATON 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State Darker Registrar

DHMH 17 Rev 1/2001

RMINGHAM

**Funeral** Director

DECEMBER 28, 2008 4:25 a.m. Baltimore, Maryland 21215-0036	4:25 a.m. 5-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any linjury or other traumatic event, the Modical Examiner must be notified at any lingury or other traumatic event, the Modical Examiner must be notified at once.	72 hours after death with the Marylar natural", or items 23a or 28a-f show dical Extraiter must be rediffed at

Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

JOHN CARTER

**Physician** /Medical

1 - State Registrar		Certif	icate of l	Death		Reg. No.	08 43100
Decedent's Name (First, Middle, Last)  Clan  Ical	John Wend	dell	Cart	er	2. Date of De Month 12		2008 4:25 a <sub>N</sub>
iner 4a. Facility Name (If not institution, give stre Stella Maris	et and number)	T	owson	Location of Death		4c. County Balt	y of Death
5. Social Security Number 050-36-2128  050-36-2128  050-36-2128	7. Age (In yrs. last I		Under 1 Year onths Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 5 7	1 <sup>y</sup> 1 <sup>y</sup> 945	9. Birthplace (State or Foreig Country) N . Y .
10a. State 10b. County	10c. City, To						10d. Inside City Limits
MD N/A	Balt	imore				10 000	XIX/es 2⊡No
10e. Street and Number 1403 N. Broadway	•		0f. Zip Code 2121	.3		10g. Citizen of USA	What Country?
11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 No If Yes, Give	If Ye	Decedent of Hi s, specify Cuba Yes 2 XNo	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	Bla	ce - American Indian, ick, White, etc. <sub>V:</sub> Black
3 Widowed 4 □ Divorced  15. Decedent's Educati	Year or Dates:	6a. Decedent	's Usual Occupa	ation			susiness/Industry 1
15. Decedent's Educati (Specify only highest grade of Elementary/Secondary (0-12) 12th Grade		(Give kind life. DO l	of work done of NOT use retired	luring most of work )	ing		unk
17. Father's Name (First, Middle, Last) Presley Carter	· · · · · · · · · · · · · · · · · · ·			18. Mother's Name		Maiden Surnar Bristo	<u> </u>
19a. Informant's Name/Relationship (Type.  Alex Carter-Son	Print) 19	9b. Mailing A		and Number or Rur den Stre			, State, Zip Code) MD 21213
20a. Method of Disposition 1 □ Burial 2 🖔 Cremation 3 □ Rem	2000	of Dispositio		e)	Date	20c. Location	- City or Town, State
4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee	Gree		nt Cem ame and Addres			Balto East F	
1 Dlandy	Warre	기 1	.101 E	. North			
23a. Part 1. Enter the disease, or combicat shock, or heart failure. List only one of	ions that caused the death. Deause on each line.	o not enter th	ne mode of dyin	g, such as cardiac	or respiratory a	rrest,	Approximate Interval Between
Immediate Cause (Final disease or condition resulting in death)	LUNG CANCER  Due to (or as a consequence	e of):					Onset and Death
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence						
JE FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown	If yes, outcome of pregnancy 1  Live birth 2 Fetal dea 4 Pregnant at time of death 9 Unknown	ath 3□Ec	topic pregnancy her <i>(specify)</i>	,			ate of delivery onth Day Year
Part II. Other significant conditions contrib	uting to death but not resulting	in the under	lying cause give	en in Part I.	23e. Did to	obacco use cont	tribute to the cause of death?
		· · · · · ·			10	/es 2□No	3X Probably 4 ☐ Unknown
Completed					24a. Was autop perfo 1 □Yes	rmed?	Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
© 25. Was case referred to medical examiner? 1 □ Yes 2 ▼ No	oital: 1 ☐ Inpatient 2 ☐ ER/0	Outpationt 3	Othe	26. Place of Death			WOODT OF
		. Time of Injury	28c. Injury Work	at		dence 6X1Oth	
27. Manner of Death  1 X Natural  2 Accident investigation  3 Suicide 6 Could not be determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, street,	factory, office		28f. Location (S City or Tov	Street and Numb vn, State)	per or Rural Route Number,
29a. Certifier 1 ☐ Certifying Physici (Check only 2 ☐ Medical Examiner one X Nurse Practit	an: To the best of my knowled : On the basis of examination a and manner stated.	lge, death oc and/or invest	curred at the tin igation, in my or	ne, date and place, pinion, death occur	and due to the red at the time,	cause(s) and m date and place,	anner as stated. and due to the cause(s)
29b. Signature and little of certifier	1 NP		29c. License	number 9792		29d. Date signe	d (Month, Day, Year)
30. Name and address of person who comp	leted cause of death (Item 23a	a) (Type, Prin	1)			-101	1
JACKIE JONES, CRNP  31. Date filed (Month, Day, Year)	2300 DULANES 32. Registrar's Signature	Y VALL	EY RD.	TIMONIUM	, MD 21	093	
ate	6 .	1					
2001	person B.	park	-			<del></del>	· · · · · · · · · · · · · · · · · · ·

DHMH 17 Rev 1/2001

ORIGINAL

1 - State Registral Reg. No 2008 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 12-23-2008 **Physician** Easter M. Cooks /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Silver Spring Manor Care Nursing Home If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Pay, Year) 06-24-1919 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 1 □ M 2 🔀 F 89 Hours Director 577-20-7513 Usual Residence of Decedent 10c. City. Town or Location 10a. State 10b. County 28a-f show ral", or items 23a or 28a-f shov SC Director Akien 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 305 Vanderbilt Dr. 29803 HSA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status and 2 should be filed within 72 hours after lealth and Mental Hygiene. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specif Black ģ 3 → Widowed 4 □ Divorced "natural". Completed th and Mental Hygiene.
7 is marked other than "natur traumatic event, the Medical 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Be Hightower <del>lysha</del> Little ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing-Address (Street and Number of Bural Route Number City & Town, Side 20 Sode) Annie S, Morton/Step-daughter Health a 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Important: If it any Injury or o once. Department of 1-2-<del>08-</del> **09** 1 Burial 2 □ Cremation 3 □ Removal from State Laurel, MD 4 ☐ Donation 5 ☐ Other (Specify) National Ceme. 21 Signature of Funeral Service Licenses 22. Name and Address of FacilityRonald Taylor II Funeral Hm 10583 Middleport Ln.White Plains,MD20695 Konsk 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Sepsis **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Multi organ Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Physician: The law requires that the death certificate be executed Urinary Tract Infection Due to (or as a consequence of): Box 68760, Physician/Medical phys the b attending p 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month 5 ☐ Other (specify) ☐Yes 2 No P.0. signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has birector, page 2 s autopsy performed? Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗷 No ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending 1 🖾 Natural 5 Pending investigation 1 ☐ Yes 2 No iours after death. 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral I

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Amend 17 & 18 per FH g887 1/22/09 TT amend Tem Type of Printin g887 lndelible lnk. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

3. Time of Death 7:57 p M

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

Ye ar

Day

2 No

1 ☐ Yes

01-09-2009

Gaithersburg, Md 20878

1 ☐Yes 2 TXTNo

DC

DHMH 17 Rev 1/2001

State

Registrar

30. Name and address of person

31. Date filed (Month,

Raman

Toul

1 2 2009

Barked

Damestown Rd

who completed cause of death (Item 23a) (Type, Print)

10810 32. régist

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Delember 29, 2008 **Physician** Archie Robert Daniels 9:40 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 8 N. Carol Street Laurel Prince Georges If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11/06/1940 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 1**X**☐ M 2☐ F 68 213-38-3998 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examinar must be indiffed at 1 Yes 2 No Director Prince Georges Laurel MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 8 N. Carol Street 20724 United States Funeral permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If itiem 27 is marked other than "natural" any injury or other traumatic excessions. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Ye ar or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No White Specify: Specify: 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Painter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Virginia Dove Archie Roberts Daniels 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rt 2, Box 30B, French Creek, WV 26218 Blanche Mullins, Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 01/02/2009 French Creek, WV Beechtown Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Harman Funeral Service, PA 21. Signature of Fu eral Service Licensee 7221 Grayburn Drive, Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 1040 **Physician** Ver disease or condition resulting in death) WIDNIC /Medical Due to (or as a consequence of) Examiner Sequentially list conditions ii any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or) Physician: The law requires that the death certificate be executed certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy 5 Other (specify) 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 1 ☐Yes 2 No 2 No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After t I or Attending Fafter death. 5 ☐ Pending investigation 1 Natural nours after death.

neral Director: Aft

filled in by the fun 1 ☐Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital c within 24 hours af To the Funeral D completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 14333 20708 LAURE SADW 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar JAN 1 4 2009

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) **Physician** 5:15 AM M December 22, 2008 Robert Davis /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Millersville Anne Arundel Knollwood Manor If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Jan 5, Birthplace (State or Foreign Country) 5. Social Security Number Days Hours 1₩ 2□ F 61 471-52-2982 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 1 ☐ Yes 2√☐ No MD Millersville Anne Arundel Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 899 Cecil Avenue South 21108 USA Completed by Funeral 12. Was Decedent Ever in U.Sunk Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Yes 2 ☒ No Specify: Race - American Indian Black, White, etc. 11. Marital Status 1 Never Married 2 Married Specify: White 3 ☐ Widowed 4 🂢 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) unk unk Elementary/Secondary (0-12) College (1-4or 5+) unk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unk unk Be မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Knollwood Manor 899 Cecil Avenue South Millersville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5\Other(Specify) in state 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 21. Signature of Tuneral Service Lix Wade 23a. Part1. Enter the disease/or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death 11554515

Physician /Medical Examiner

permit. Pages 1
Department of H
Important: If ite
any injury or ot
once.

**Funeral** 

Director

iral", or Items 23a or 28a-f show Examiner must be notified at

item 27 is marked other than "natu other traumatic event, the Medical

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

attending physician and for use as the burial-transit ed by the a detached f signed I cate has l page 2 s within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral.

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

	disease or condition resulting in death)	a. AT HEILOSC Due to (or as a conseq		(AK)10VA	CUCAR	Ul JUAJE	YCHICS
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a conseq c. Due to (or as a conseq					
Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	.d	il death 3 ☐ Ectopic p			23d. Date of deli Month	very Day Year
Completed by Phy	Part II. Other significant conditions of	ontributing to death but not res	ulting in the underlying	cause given in Part I.	23e. Did tob:  1  Ye:  24a. Was an autopsy perform 1  Yes 2	24b. Were au prior to death?	
Be	25. Was case referred to medical examiner?			26. Place of De	eath (Check only one	)	
	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 D	OA Other: 4 Nursing	Home 5 ☐ Resider	nce 6 Other (Spec	cify)
ation:	27. Manner of Death  Natural 5 Pending  Description	the second secon	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how	w injury occurred	
Medical Certification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At he building, etc. (Special	ome, farm, street, facto	ry, office	28f. Location (Str. City or Town,	eet and Number or Ru State)	ral Route Number,
edica! (		ysician: To the best of my knoniner: On the basis of examination and manner stated.					
Š	29b. Signature and title of certifier	1 1	2:	c. License number	29	d. Date signed (Mont)	n, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

30. Name and address of person who com

JAN 1

31. Date filed (Month, Day, Year)

32 Registrar's Signature

D31136 DECEMBER 31, 2008

KILBRIDE RD, BATTIMORE, MD 21236

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-00001 State of Maryland / Department of Health and Mental Hygiene Darryl Robert Elliott 43192 2008 Certificate of Death 1- For State Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ 2319 hrs December 31, 2008 Medical Examiner ROBERT DARRYL ELLIOTT 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's Prince Georges Hospital Center Cheverly 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min Months Days Hours Country) DC Director 55 03-11-1953 577-72-7310 Yrs M 2 X F Usual Residence of Deceden 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 X Yes 2 No s 23a or 28a-f show e notified at once, WASHINGTON Pages 1 and 2 should be filed within 72 hours after death with the Maryland Director 10g. Citizen of What Country 10f, Zip Code 10e. Street and Number 20019 USA 3363 CLAY STREET NE 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S Funeral 11. Marital Status or items ; If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? Never Married Married 2 X No Yes Specify. BLACK If Yes, Give Yea Yes 2 X No specify: 3 Widowed 4 X Divorced Examiner "natural" ģ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Coilege (1-4 or 5+ Elementary/Secondary (0-12) item 27 is marked other than ' 21215-0036 PRIVATE SECURITY GUARD 12TH of Health and Mental Hygiene. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be GERALDINE MCCLENDON MORRIS ELLIOTT 19a Informant's Name/Relationship (Type, Print ) **Geraldine** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 呈 NEWASHINGTON, DC GERADINE E. ELLIOTT 3363 CLAY STREET, 20c. Location - City or Town, State Date 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery) ltimore, crematory or other place) t: If i X Burial 2 Cremation 3 Removal from State Department tant: OUANTICO NATIONAL CEM |01-21**-**2009| TRIANGLE, VA Other Specify. Donation 5 22. Name and Address of Facility MARSHALL S FUNERAL HOME OF MD ature of Mne Servi Licensee 4308 SUITLAND ROAD SUITLAND, DONALD R. GRAY Approximate Interva or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart 1. Enter the disea Physician Between Onset and lure. List only one cause on each line Death Medical a. Multiple Injuries Impediate Cause (Final disease kaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit Physician/Medical AMENDED Item#19a, PerFH, G888, 2/3/09, WS UNPENDED e attending physician for use as the burial Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy Year 3 Ectopic pregnancy Day 23b. Was decedent pregnant in the Month Live birth Fetal death past 12 months Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown signed by the the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o δ Yes 2 ✔ No 3 Probably 4 Unknown Completed Division of Vital Records, 24a. Was an 24b. Were autopsy findings available page 2 should peen autopsy prior to completion of cause of death? has performed? No Yes 2 **V** certificate 26.Place of Death (Check only one) Hospital or Attending Physician: director, 25. Was case referred to medical Be Other<sub>4</sub> examiner? Hospital: Other Nursing Home 5 Residence 6 DOA Inpatient 2 V ER/Outpatient 3 this 1 ✓ Yes No 28a. Date of Injury 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 28b. Time of Injury Pedestrian struck by auto Dec 31, 2008 1825 hrs Natural Yes 2 V No To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Pending filled in by the 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be or Town, State) Eastbound Route 202 & Brightseat Road, Landover, MD determined (Specify) Major Road / Highway Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and title of certifie January 1, 2009 O.C.M.E. of persop who completed cause of death (Item 23a) OCME Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201 Mary G. Rippie MD. 32. Registrar's Signature State

Registra

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 43193

		For State			Certific	cate of D	Death				leg. No.			
Physician/	1.	Decedent's Name (First, Middle	,Last)						2	Month	Day	Year		ime of Death 840 hrs
l Examine		Desiree Edwar	ds	and assembles)		I Ab	. City, Town, c	r Location of	Death	Decembe		unty of D		72.01
	4a	<ul> <li>Facility Name (if not institution Johns Hopkins Bayviev</li> </ul>		na number)			Baltimore	: Location of	Death .		40.00	only or D	Cutti	
uneral	5.		6. Sex	7. Age (Ir	n yrs. last bi	irthday)	If Under 1 Ye	ar If Under	24Hrs:	8. Date of B	irth(MM/DD/			ce (State or
irector	1					"	Months Da		Min.		0 10		oreign Country	)
	110	sual Residence of Decedent	1 M 2	XF	47	Yrs.	l	11511		Aug 2	2. 196			<sup>)</sup> Maryland
Ŷu .	_	Da. State 10b. County		100	c. City, Tow	vn or Location	1						100	I. Inside City Limits
10w 2		MD Balt	imore		D	unda1k	c						1	Yes 2 X No
cto	3 10	De. Street and Number				1	10f. Zip Code			977	10g. Citizen	of What	Country?	
n or 28a-f sh iffied at onc		819 N. Avondal	e Stre	et		1	21	222				USA		
2 2		1. Marital Status	12. Wa	s Decedent Eve	er in U.S.		Decedent of H				0- 14.			Indian, Black,
or items 22 must be no	1	X Never Married 2 Mar	illeu	ned Forces? Yes 2 X	No	If Yes	s, specify Cuba	an, Mexican,	Puerto F	Rican, etc.)		White, e	tc.	
, in		Widowed 4 Divo	orced If Yes, G		140	1 Y	es 2X N	o specify:			Spe	ecify: T	white	20.37
amine d by		15. Decedent's Education (Spec	ify only highe	st grade comple	eted) 16a		S Usual Occup				k 16b, Kind	of Busin	ess/Indus	stry unk
lygiene. other than "natu he Medical Exar		Elementary/Secondary (0-12)	Coll	ege (1-4 or 5+)		during mos	st of working in	e, DO NOT C	JSC TELLIC	su) ·				
2 stocks by the second water than "nature to the second when a Hygiene 27 is marked other than "nature repent, the Medical Examples of the Completed I		12		0										, . , , ,
Hygi the the		7. Father's Name (First, Middle,						1		First, Middle,		rname)		
Mental marked r event,		Hobert Edwar				10h Mailine A	Address (Str			Gold		ar Town	State 7in	Code)
Health and Mental Hygiene, item 27 is marked other the remnatic eyent, the Mee To Be Com!	- 4	9a. Informant's Name/Relationsh Regina Riley/s		nt).			Mcginn							(Code)
alth a		Da. Method of Disposition	13661				on (Name of c		. IC II	Date			ity or Tow	n, State
ું કુ <u>કુ</u> કુ	1		3 Rem	oval from State		natory or othe		,,						
ment fant: or of	4	Donation 5 X Other Sp	egify: in	state		3.4								
Department Important: injury or of	2'	1. Signature of Funeral Service	censee Walls	, Mixed	tor	Stat	me and Addre	ss of Facility	oard	655 W	. Bal	timo	re S	treet
	1	3a. Par I. Enter the disease or	1/0	ue		Balt	timore,	MD 2	2120	1 respiratory a	rrest shock	or heart	ΙΔ	pproximate Interva
sician						not enter the								
	1	failure. List only one cause	on each line.										'	Between Onset and
ledical	In	failure. List only one cause on mmediate Cause (Final disease	on each line. a. <b>Co</b> 1	nplicat	ions								'	Between Onset and
ledical	In	failure. List only one cause of mmediate Cause (Final disease or condition resulting in death)	on each line. a. <b>Co</b> 1		ions								'	Between Onset and
dical aminer	In	failure. List only one cause on mmediate Cause (Final disease	a. Con  Due to (	nplicat	ions (								'	Between Onset and
l dical aminer	In	failure. List only one cause of mmediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, any, leading to immediate ause. Enter Underlying Cause	a. Con  Due to (a. Due	nplicat or as a consequ or as a consequ	ions (								'	Between Onset and
aminer	In	failure. List only one cause of mmediate Cause (Final disease or condition resulting in death) sequentially list conditions, any, leading to immediate	a. Con  Due to (a. Due	nplicat or as a consequ	ions (								'	Between Onset and
dical iminer	Examiner Siff of (I)	failure. List only one cause of mmediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, any, leading to immediate hause. Enter Underlying Cause Disease or injury that initiated events resulting in death) Last	b. Due to (c) Due to (d) d.	nplicat or as a consequ or as a consequ or as a consequ	ions pence of): pence of):	of Ace	tamino	phen a	ınd a	alcoho	l into		'	Between Onset and
aminer	Examiner Siff of (I)	failure. List only one cause of mmediate Cause (Final disease or condition resulting in death) sequentially list conditions, any, leading to immediate ause. Enter Underlying Cause Disease or injury that initiated events resulting in death) Last	a. COI Due to (c) Due to (c) Due to (c) Due to (c) AMEN	mplicat or as a consequ or as a consequ or as a consequ or as a consequ DED 23a	ions pence of): pence of): pence of):	of Ace		phen a	ınd a	alcoho	1 into	oxica	ation	Between Onset and
dical iminer	Medical Examiner on Signification of Sig	failure. List only one cause of mmediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, any, leading to immediate only leading to immediate observed or injury that initiated events resulting in death) Last  **UNPENDED**  **FEMALE: bb. Was decedent pregnant in the cause of the ca	a. Con Due to (r b. Due to (r c. Due to (r d. AMEN	nplicat or as a consequ or as a consequ or as a consequ	ions pence of): pence of): pence of):	of Ace	tamino 28a-f	phen a	g88	alcoho	1 into		ation	Between Onset and
dical iminer	Medical Examiner on Signification of Sig	failure. List only one cause of mmediate Cause (Final disease or condition resulting in death)  sequentially list conditions, fany, leading to immediate ause. Enter Underlying Cause Disease or injury that initiated events resulting in death) Last  **INPENDED**  **FEMALE:  3b. Was decedent pregnant in the past 12 months?	a. COI  Due to (i  b. Due to (i  c. Due to (i  d. AMEN  23c. 1	mplicat or as a consequence as a consequ	ions  uence of):  uence of):  uence of):  of pregnance	II,27,	tamino 28a-f	phen a	g88	alcoho	1 into	Date of de	ation	Setween Onset and Death
dical iminer	Sician/Medical Examiner Sician/Medical Examiner 1	failure. List only one cause of mmediate Cause (Final disease or condition resulting in death) sequentially list conditions, any, leading to immediate ause. Enter Underlying Cause Disease or injury that initiated events resulting in death) Last  X UNPENDED  FEMALE:  Bb. Was decedent pregnant in the past 12 months?  Yes 2 No 9 V Unk	a. COI Due to (c) Due to (c) Due to (c) AMEN  a. COI Due to (c)  d	or as a consequence or as	ions (ience of):  ience of):  ience of):  preme of):  preme of death	II,27,	28a-f	per me	g88	88 2-2-	-09	Date of de	ation	Setween Onset and Death
miner	Physician/Medical Examiner	failure. List only one cause of mediate Cause (Final disease or condition resulting in death)  Gequentially list conditions, any, leading to immediate ause. Enter Underlying Cause Disease or injury that initiated events resulting in death) Last  WUNPENDED  FFEMALE:  3b. Was decedent pregnant in the past 12 months?  Yes 2 No 9 V Unk  Part II. Other significant conditions.	a. COI Due to (c) Due to (c) Due to (c) AMEN  a. COI Due to (c)  d	or as a consequence or as	ions (ience of):  ience of):  ience of):  preme of):  preme of death	II,27,	28a-f	per me	g88	23e. Did	-09	Date of de	elivery Day	Setween Onset and Death  Year  cause of death?
ned by the attending physician and cleached for use as the burial - transit by Dhysician/Madical Examiner	by Physician/Medical Examiner  L SEAL BOOK OF THE STANDARY	failure. List only one cause of mmediate Cause (Final disease or condition resulting in death) sequentially list conditions, any, leading to immediate ause. Enter Underlying Cause Disease or injury that initiated events resulting in death) Last  X UNPENDED  FEMALE:  Bb. Was decedent pregnant in the past 12 months?  Yes 2 No 9 V Unk	a. COI Due to (c) Due to (c) Due to (c) AMEN  a. COI Due to (c)  d	or as a consequence or as	ions (ience of):  ience of):  ience of):  preme of):  preme of death	II,27,	28a-f	per me	g88	23e. Did	-09 23d. [ Me tobacco use	Date of deponth	allivery Day	Year  cause of death?  y 4  Unknown
ned by the attending physician and cleached for use as the burial - transit and burial - transit and by Dhysician/Medical Examiner	by Physician/Medical Examiner  L EST Physician	failure. List only one cause of mediate Cause (Final disease or condition resulting in death)  Gequentially list conditions, any, leading to immediate ause. Enter Underlying Cause Disease or injury that initiated events resulting in death) Last  WUNPENDED  FFEMALE:  3b. Was decedent pregnant in the past 12 months?  Yes 2 No 9 V Unk  Part II. Other significant conditions.	a. COI Due to (c) Due to (c) Due to (c) AMEN  a. COI Due to (c)  d	or as a consequence or as	ions (ience of):  ience of):  ience of):  preme of):  preme of death	II,27,	28a-f	per me	g88	23e. Did 1 Y 24a. Wa aut	-09  23d. E Me  tobacco use  (es 2 N  ss an opsy	Date of deponth  e contribution 3  24b. We price	elivery Day  te to the Probablere autopror to com	Year  cause of death?  y 4 Unknown sy findings availabl
as been signed by the attending physician and 2 should be detached for use as the burial - transit and busician/Medical Examiner	by Physician/Medical Examiner  L EST Physician	failure. List only one cause of mediate Cause (Final disease or condition resulting in death)  Gequentially list conditions, any, leading to immediate ause. Enter Underlying Cause Disease or injury that initiated events resulting in death) Last  WUNPENDED  FFEMALE:  3b. Was decedent pregnant in the past 12 months?  Yes 2 No 9 V Unk  Part II. Other significant conditions.	a. COI Due to (c) Due to (c) Due to (c) AMEN  a. COI Due to (c)  d	or as a consequence or as	ions (ience of):  ience of):  ience of):  preme of):  preme of death	II,27,	28a-f	per me	g88	23e. Did 1 Y	-09 23d. C	Date of deponth  e contribution of the print	altion  Blivery Day  Ute to the Probablere autopo	Setween Onset and Death  Year  cause of death?
cate has been signed by the attending physician and page 2 should be detached for use as the burial - transit	Completed by Physician/Medical Examiner  A L SH B B C SH B	failure. List only one cause of mediate Cause (Final disease or condition resulting in death)  Gequentially list conditions, any, leading to immediate ause. Enter Underlying Cause Disease or injury that initiated events resulting in death) Last  WUNPENDED  FFEMALE:  3b. Was decedent pregnant in the past 12 months?  Yes 2 No 9 V Unk  Part II. Other significant conditions.	a. Con Due to (c) Due to (c) Due to (c)  AMEN  AMEN  23c. 1 4  g  ions contrib	or as a consequence or as	ions (ience of):  ience of):  ience of):  preme of):  preme of death	II,27,	28a-f al death er (Specify) aderlying caus	per me	g88	23e. Did 1 Y 24a. Wat per 1 Yes	-09  23d. [ Me  tobacco use fes 2 [ Nes an opery formed?	Date of deponth  e contribution of the print	Day  The to the Probable are autoport to commutath?	Year  cause of death?  y 4 V Unknown sy findings available
cate has been signed by the attending physician and page 2 should be detached for use as the burial - transit	Se Completed by Physician/Medical Examiner  The completed by Physician Physician Carlon Phy	failure. List only one cause of mediate Cause (Final disease or condition resulting in death)  Gequentially list conditions, any, leading to immediate only leading to immediate ovents resulting in death)  Was unpended  FEMALE:  But Was decedent pregnant in the past 12 months?  Yes 2 No 9 Vunk  Part II. Other significant conditions are conditionally as the conditions of	a. COI  Due to (i b. Due to (i d. AMEN  AMEN  a. COI  Due to (i d. 4 4 4 4 4 6 7 7 7 7 7 7 7 7 7 7 7 7 7 7	mplicat or as a consequence as a consequ	ions ience of): ience of): ience of): of pregnance ine of death	II,27,	28a-f al death er (Specify) anderlying caus	per me	g88	23e. Did 1 Y 24a. Wat per 1 Yes	-09  23d. [ Me  tobacco use fes 2 [ Nes an opery formed?	Date of deponth  24b. We pring deeponth	Day  The to the Probable are autoport to commutath?	Year  cause of death?  y 4 V Unknown sy findings available
Trips certificate has been signed by the attending physician and trips certificate has been signed by the attending physician and trips a should be detached for use as the burial - transit	10 Be completed by Physician/Medical Examiner	failure. List only one cause of mmediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, any, leading to immediate ause. Enter Underlying Cause Disease or injury that initiated events resulting in death) Last  WUNPENDED  FEMALE:  Bb. Was decedent pregnant in the past 12 months?  Yes 2 No 9 V Unkerart II. Other significant conditions are use.  Cocaine use.	a. COI  Due to (i  b. Due to (i  d. AMEN  AMEN  anown g  Hospital:	nplicat or as a consequence as a consequ	ions  ience of):  ience of):  pt.  pt.  of pregnance of death  ut not resul	II,27,	28a-f al death er (Specify) aderlying caus	per me  Bectopic  Geographic given in Pa	g88 pregnal	23e. Did 1 Yes	-09  23d E  tobacco use les 2 No les an lopsy formed? S 2 No  Residence	Date of deponth  24b. We printed detection of the printed detection of	Day  Day  Day  Probable are autopor to commath?  Yes  Other:	Year  cause of death?  y 4 V Unknown sy findings available
After this certificate has been signed by the attending physician and fineral director, page 2 should be detached for use as the burial - transit or To Bo Completed by Dhyseician/Medical Examiner	10 Be completed by Physician/Medical Examiner	failure. List only one cause of mediate Cause (Final disease or condition resulting in death)  Gequentially list conditions, any, leading to immediate ause. Enter Underlying Cause Disease or injury that initiated events resulting in death) Last  WUNPENDED  FFEMALE:  3b. Was decedent pregnant in the past 12 months?  Yes 2 No 9 V Unk  Part II. Other significant conditions are used.  Cocaine use  5. Was case referred to medical examiner?  1 Ves 2 No	a. COI Due to (i b. Due to (i d. AMEN AMEN AMEN Hospital: 28a	inplicat.  or as a consequence as a cons	ions ience of): ience	Of Ace  II,27,  cy 2 Feta 5 Othe  Iting in the un	28a-f al death er (Specify) aderlying caus  26.Pla 3 DOA jury 28c. Ir	per me  B Ectopic  B Given in Pa	g88	23e. Did 1 Yes 24a. Wa aut per 1 Yes ponly one) g Home 5	-09  23d E Me tobacco use es 2 No Residence e how injury	Date of deponth  24b. We printed detection of the printed detection of	Day  Day  Day  Probable are autopor to commath?  Yes  Other:	Year  cause of death?  y 4 V Unknown sy findings available
After this certificate has been signed by the attending physician and functed for use as the burial - transit or To Bo Completed by Physician/Medical Examiner	10 Be completed by Physician/Medical Examiner	failure. List only one cause of mediate Cause (Final disease or condition resulting in death)  Gequentially list conditions, any, leading to immediate ause. Enter Underlying Cause Disease or injury that initiated events resulting in death) Last  WUNPENDED  FFEMALE:  But UNPENDED  FFEMALE:  But UNPENDED  FOR A COCAINE USE  COCAINE USE  Solution:  The Was a decedent pregnant in the past 12 months?  COCAINE USE  Solution:  Neart II. Other significant conditions are used to medical examiner?  1 V Yes 2 No  7. Manner of Death  Natural 5 Pend Investigations are used.	a. COI  Due to (c)  Due to (c)  Due to (c)  Due to (c)  AMEN  AMEN  AMEN  Hospital:	mplicat  or as a consequence as a conse	ions ience of): ience of ience of): ience of ience of): ience of of ience	of Ace  II,27,  cy 2 Feta 5 Othe  Iting in the un	28a-f al death er (Specify) aderlying caus  26.Pla 3 DOA jury 28c. Ir	per me  B Ectopic  B Ectopic  C of Death Other; Diury at Work Yes 2 X	g88	23e. Did 1 Y 24a. Wa aut per 1 Y Yes only one) g Home 5 28d. Describ unkno	-09  23d. E Me  tobacco use fes 2 No  Residence e how injury	Date of deponth  e contribute 24b. We printed der 1  e 6  Number	altion Day  Late to the Probable ere autopor to commath? Yes Other:	Year  Cause of death?  y 4  Unknown sy findings available pletion of cause of 2  No
iter death.  Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial - transit fecation. To Be Completed by Dhyeician/Madical Examiner	10 Be completed by Physician/Medical Examiner	failure. List only one cause of mediate Cause (Final disease or condition resulting in death)  Gequentially list conditions, any, leading to immediate Disease or injury that initiated events resulting in death) Last  Well UNPENDED  FEMALE:  3b. Was decedent pregnant in the past 12 months?  Yes 2 No 9 Vunk  Fart II. Other significant conditions are used to medical examiner?  1 Yes 2 No  7. Manner of Death  1 Natural 5 Pend Investigations of Suicide 6 X Could deter	a. COI  Due to (i  b. Due to (i  d. AMEN  AMEN  AMEN  Hospital:  28a  ding stigation d not be	nplicat or as a consequence as a conseq	ions ience of): ience of ience of): ience of ience of): ience of of ience	of Ace  II,27,  cy 2 Feta 5 Othe  Iting in the un	28a-f al death er (Specify) aderlying caus  26.Pla 3 DOA jury 28c. Ir	per me  B Ectopic  B Ectopic  C of Death Other; Diury at Work Yes 2 X	g88	23e. Did 1 Y 24a. Wa aut per 1 Y Yes only one) g Home 5 28d. Describ unkno	-09  23d. E Me  tobacco use fes 2 No  Residence e how injury	Date of deponth  e contribute 24b. We printed der 1  e 6  Number	altion Day  Late to the Probable ere autopor to commath? Yes Other:	Year  Cause of death?  y 4  Unknown sy findings available pletion of cause of 2  No
hours after death.  neral Director: After this certificate has been signed by the attending physician and  y filled in by the funeral director, page 2 should be detached for use as the burial - transit  Certification: To Be Completed by Physician/Medical Examiner	Certification: To be Completed by Physician/Medical Examiner	remediate Cause (Final disease or condition resulting in death)  sequentially list conditions, any, leading to immediate ause. Enter Underlying Cause Disease or injury that initiated events resulting in death) Last  VENPENDED  FEMALE:  3. Was decedent pregnant in the past 12 months?  Ves 2 No 9 Vunk  Vart II. Other significant conditions are used to medical examiner?  1 Ves 2 No  7. Manner of Death  1 Natural 5 Pend  2 Accident Investigation Pend  3 Suicide 6 Could deter  9a. Certifier 1 Certifying Pend  9a. Certifier 1 Certifying Pend	a. COI Due to (i b. Due to (i d. AMEN  AMEN  AMEN  Hospital:  Hospital:  28a  4 (s)	inplicat or as a consequence as a conseq	ions ience of): ience	of Ace  II,27,  cy 2 Feta 5 Othe  Iting in the un  R/Outpatient Bb. Time of Inj  Inknown e, farm, street	28a-f al death er (Specify) aderlying caus  26.Pla 3 DOA jury 28c. In n, factory, officed at the time.	per me  Bectopic  Bectopic	g88 pregnal rt I. (Check c Nursing? No	23e. Did 1 Yes 24a. Wa aut 1 Yes 28d. Describ unkno 28f. Locatior or Town 819N. due to the ca	-09  23d E  tobacco user les 2 No  Residence how injury  Nan (Street and State)  Avonc	Date of deconth  24b. We pride decontribute occurred  Number  1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Day  Day  Day  Day  Day  Drobablere autopor to comath?  Yes  Other:  Ave.  s stated.	Year  Cause of death?  y 4 V Unknown sy findings available pletion of cause of 2 No  Route Number, City
hours after death.  neral Director: After this certificate has been signed by the attending physician and  y filled in by the funeral director, page 2 should be detached for use as the burial - transit  Certification: To Be Completed by Physician/Medical Examiner	Certification: To be Completed by Physician/Medical Examiner	failure. List only one cause of mediate Cause (Final disease or condition resulting in death)  dequentially list conditions, any, leading to immediate ause. Enter Underlying Cause Disease or injury that initiated events resulting in death) Last  Value UNPENDED  FEMALE:  3. Was decedent pregnant in the past 12 months?  1. Ves 2 No 9 V Unk  1. Other significant conditions are used.  Cocaine use  1. Ves 2 No  7. Manner of Death  1. Natural 5 Pend Inves  3. Suicide 6 X Could deter  4. Homicide	a. COI  Due to (i b. Due to (i d. AMEN  AMEN  AMEN  Hospital:  Hospital:  28a  ding stigation d not be cmined (s)	nplicat  or as a consequence as a conse	ions ience of): ience	of Ace  II,27,  cy 2 Feta 5 Othe  Iting in the un  R/Outpatient Bb. Time of Inj  Inknown e, farm, street	28a-f al death er (Specify) aderlying caus  26.Pla 3 DOA jury 28c. In n, factory, officed at the time.	per me  Bectopic  Bectopic	g88 pregnal rt I. (Check c Nursing? No	23e. Did 1 Yes 24a. Wa aut 1 Yes 28d. Describ unkno 28f. Locatior or Town 819N. due to the ca	-09  23d E  tobacco user les 2 No  Residence how injury  Nan (Street and State)  Avonc	Date of deconth  24b. We pride decontribute occurred  Number  1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Day  Day  Day  Day  Day  Drobablere autopor to comath?  Yes  Other:  Ave.  s stated.	Year  Cause of death?  y 4 V Unknown sy findings available pletion of cause of 2 No  Route Number, City
hours after death.  neral Director: After this certificate has been signed by the attending physician and  y filled in by the funeral director, page 2 should be detached for use as the burial - transit  Certification: To Be Completed by Physician/Medical Examiner	edical Certification: To be completed by Physician/Medical Examiner	remediate Cause (Final disease or condition resulting in death)  sequentially list conditions, any, leading to immediate ause. Enter Underlying Cause Disease or injury that initiated events resulting in death) Last  VENPENDED  FEMALE:  3. Was decedent pregnant in the past 12 months?  Ves 2 No 9 Vunk  Vart II. Other significant conditions are used to medical examiner?  1 Ves 2 No  7. Manner of Death  1 Natural 5 Pend  2 Accident Investigation Pend  3 Suicide 6 Could deter  9a. Certifier 1 Certifying Pend  9a. Certifier 1 Certifying Pend	a. COI  Due to (i b. Due to (i d. AMEN  A AMEN  A AMEN  B AMEN  Grown g  Grown contrib  Hospital:  28a  ding stigation d not be rmined (so the miner: To miner: On the and me and	inplicat or as a consequence as a conseq	ions ience of): ience	of Ace  II,27,  cy 2 Feta 5 Othe  Iting in the un  R/Outpatient Bb. Time of Inj  Inknown e, farm, street	28a-f al death er (Specify) aderlying caus  26.Pla 3 DOA jury 28c. In 1 t, factory, office ed at the time, on, in my opin	per me  Bectopic  Bectopic	g88 pregnal rt I. (Check c Nursing? No	23e. Did 1 Yes 24a. Wa aut 1 Yes 28d. Describ unkno 28f. Locatior or Town 819N. due to the ca	1 into	Date of deponth  e contribute  24b. We prince dee 1  occurred  Number  lale manner a e, and due	Day  Lite to the Probable Prob	Year  Cause of death?  y 4 V Unknown sy findings available pletion of cause of 2 No  Route Number, City
hours after death.  neral Director: After this certificate has been signed by the attending physician and  filled in by the funeral director, page 2 should be detached for use as the burial - transit  Certification: To Be Completed by Divercian/Medical Examiner	Certification: To be Completed by Physician/Medical Examiner	failure. List only one cause of mmediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, any, leading to immediate ause. Enter Underlying Cause Disease or injury that initiated events resulting in death) Last  WUNPENDED  FEMALE:  Bb. Was decedent pregnant in the past 12 months?  Yes 2 No 9 V Unkerart II. Other significant conditions are used to medical examiner?  I Ves 2 No  Tocaine use  Sequentially list conditions are used to medical examiner?  I Natural 5 Pend I Natural 7 Pend I Natural 8 Pend I Natural 9 Pend I Natural 9 Pend I Pend	a. COI  Due to (i b. Due to (i d. AMEN  A AMEN  A AMEN  B AMEN  Grown g  Grown contrib  Hospital:  28a  ding stigation d not be rmined (so the miner: To miner: On the and me and	nplicat  or as a consequence as a conse	ions ience of): ience	of Ace  II,27,  cy 2 Feta 5 Othe  Iting in the un  R/Outpatient Bb. Time of Inj  Inknown e, farm, street	28a-f al death er (Specify)  26.Pla 3 DOA jury 28c. In t, factory, offic ed at the time, on, in my opin 29c. Lice	phen a  per me  B Ectopic  B Given in Pa  Control  Contro	g88 pregnal rt I. (Check c Nursing? No	23e. Did 1 Yes 24a. Wa aut 1 Yes 28d. Describ unkno 28f. Locatior or Town 819N. due to the ca	-09  23d E  tobacco user les 2 No  Residence how injury  Non (Street and State)  Avono  Use(s) and reand place	Date of deconth  24b. We pride decontribute occurred  Number  1 value manner a contribute signed	Day  Lite to the Probable Prob	Year  Cause of death?  y 4 V Unknown sy findings available pletion of cause of 2 No  Route Number, City  Dundal  ause(s)  Day, Year)
hours after death.  neral Director: After this certificate has been signed by the attending physician and  filled in by the funeral director, page 2 should be detached for use as the burial - transit  Certification: To Be Completed by Divercian/Medical Examiner	Medical Certification: To be Completed by Physician/Medical Examiner    Completed by Physician/Medical Examiner   Completed by Physician/Medical Examiner   Completed by Physician/Medical Examiner   Completed by Physician/Medical Examiner   Completed by Physician/Medical Examiner   Completed by Physician/Medical Examiner   Completed by Physician/Medical Examiner   Completed by Physician/Medical Examiner   Completed by Physician/Medical Examiner   Completed by Physician/Medical Examiner   Completed by Physician/Medical Examiner   Completed by Physician/Medical Examiner   Completed by Physician/Medical Examiner   Completed by Physician/Medical Examiner   Completed by Physician/Medical Examiner   Completed by Physician/Medical Examiner   Completed by Physician/Medical Examiner   Completed by Physician   Completed	failure. List only one cause of mediate Cause (Final disease or condition resulting in death)  Gequentially list conditions, any, leading to immediate ause. Enter Underlying Cause Disease or injury that initiated events resulting in death) Last  WUNPENDED  FFEMALE:  By UNPENDED  FFEMALE:  By UNPENDED  FORMALE:  By UNPENDED  By UNPENDED  FORMALE:  By UNPENDED  FORMALE:  By UNPENDED  FORMA	a. COI Due to (i b. Due to (i d. AMEN  AMEN  Anown g  Gions contrib  Hospital:  28a  4 (s)  Aminer: On the and maler  Anown g  Anown and maler  Anown anown and maler  Anown anown and maler  Anown and maler  Anown and maler  Anown and maler  Ano	inplicat or as a consequence between the pregnant at time. Unknown uting to death but in the precipitation of the precipi	ions lience of): l	of Ace  II,27,  cy 2 Feta 5 Othe  Iting in the un  R/Outpatient Bb. Time of Inj  Inknown e, farm, street  death occurre for investigation	28a-f al death er (Specify)  26.Pla 3 DOA jury 28c. In t, factory, offic ed at the time, on, in my opin 29c. Lice	per me  B Ectopic  B Ectopic  C of Death Other O	g88 pregnal rt I. (Check c Nursing? No	23e. Did 1 Yes 24a. Wa aut 1 Yes 28d. Describ unkno 28f. Locatior or Town 819N. due to the ca	-09  23d E  tobacco user les 2 No  Residence how injury  Non (Street and State)  Avono  Use(s) and reand place	Date of deconth  24b. We pride decontribute occurred  Number  1 value manner a contribute signed	Day  Day  Day  Day  Day  Day  Drobablere autopor to comath?  Yes  Other:  Salar autopor to comath?  Other:  Garage autopor to comath?	Year  Cause of death?  y 4 V Unknown sy findings available pletion of cause of 2 No  Route Number, City  Dundal  ause(s)  Day, Year)
hours after death.  neral Director: After this certificate has been signed by the attending physician and  y filled in by the funeral director, page 2 should be detached for use as the burial - transit  Certification: To Be Completed by Diversian/Medical Examiner	Medical Certification: To be Completed by Physician/Medical Examiner    Completed by Physician/Medical Examiner   Completed by Physician/Medical Examiner   Completed by Physician/Medical Examiner   Completed by Physician/Medical Examiner   Completed by Physician/Medical Examiner   Completed by Physician/Medical Examiner   Completed by Physician/Medical Examiner   Completed by Physician/Medical Examiner   Completed by Physician/Medical Examiner   Completed by Physician/Medical Examiner   Completed by Physician/Medical Examiner   Completed by Physician/Medical Examiner   Completed by Physician/Medical Examiner   Completed by Physician/Medical Examiner   Completed by Physician/Medical Examiner   Completed by Physician/Medical Examiner   Completed by Physician/Medical Examiner   Completed by Physician   Completed	failure. List only one cause of mediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, any, leading to immediate ause. Enter Underlying Cause Disease or injury that initiated events resulting in death) Last  WUNPENDED  FFEMALE:  b. Was decedent pregnant in the past 12 months?  Yes 2 No 9 Vunk  Part II. Other significant conditions are use.  Cocaine use  5. Was case referred to medical examiner?  1 Ves 2 No  7. Manner of Death  Natural 5 Pend  1 Natural 5 Pend  2 Accident Inves  3 Suicide 6 Could deter  19a. Certifier Check only 2 Medical Examiner)  19b. Signature and title of certification.  Natural 10 Certifying Processors.	a. COI Due to (i b. Due to (i d. AMEN  Amen  Anown g  Ging contrib  Hospital:  28a  4 (s)  Anysician: To miner: On the and mater  who complete	inplicat or as a consequence between the pregnant at time. Unknown uting to death but in the precipitation of the precipi	ions ience of): ience	II,27, Cy 2 Feta 5 Other Iting in the un  R/Outpatient Bb. Time of Inj Inknowr e, farm, street  death occurre or investigation	28a-f al death er (Specify)  26.Pla 3 DOA jury 28c. In t, factory, offic ed at the time, on, in my opin 29c. Lice	phen a  per me  B Ectopic  B Ectopic  C Other  Joyry at Work  Yes 2 X  B building, etc.  date and platon, death oceans number  C.M.E.	g88 pregnal rt I.  (Check c Nursing P No c.	23e. Did 1 Y 24a. Wa aut 1 Yes only one) g Home 5 28d. Describ unkno 28f. Location or Town 819N. due to the cat the time, da	-09  23d E  tobacco user les 2 No  Residence how injury  Non (Street and State)  Avono  Use(s) and reand place	Date of deconth  24b. We pride decontribute occurred  Number  1 value manner a contribute signed	Day  Day  Day  Day  Day  Day  Drobablere autopor to comath?  Yes  Other:  Salar autopor to comath?  Other:  Garage autopor to comath?	Year  Cause of death?  y 4 V Unknown sy findings available pletion of cause of 2 No  Route Number, City  Dundal  ause(s)  Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-09864 State of Maryland / Department of Health and Mental Hygiene Kathy Jean Helbig 1- For State Certificate of Death Reg. No Registrar 2. Date of Death Decedent's Name (First, Middle,Last) Physician/ December 31, 2008 0803 hrs Medical Examiner Cathy Jean Helbig 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Baltimore County** Rosedale 1319 Evering Avenue 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 24Hrs. 7. Age (In yrs. last birthday) If Under 5. Social Security Number 6. Sex **Funeral** Min Months Davs Hours Country) Maryland Director Mar 10. 219-60-6086 58 1950 2X F M Usual Residence of Decedent 10d. Inside City Limits 10a, State 10c. City, Town or Location Ob. County Yes 2 X No Baltimore Rosedale or items 23a or 28a-f show must be notified at once. death with the Maryland Director 10f. Zip Code 10g, Citizen of What Country 10e. Street and Number 1319 Evering Avenue 21237 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Funeral 11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 Married Yes 2 X No 4 X Divorced Yes 2 X No specify: Imore, MD 21215-0036

Pages 1 and 2 should be filed within 72 hours after onen of Heafth and Mental Hygiene and The and Mental Hygiene and Internal, of one other transmatic event, the Medical Examiner. Yes, Give Yea Specify: white Widowed 2 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+ Elementary/Secondary (0-12) 12 2 registered nurse healthcare 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Joseph Eugene Wilson Elnora Belle Marsteller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Karen Vernago/sister 10 Hoban Court Baltimore, MD 21236 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery 20a. Method of Disposition Baltimore, crematory or other place) anent or aportant: If is a y or o' Removal from State Burial 2 Cremation 3 X Donation 5 Other Specify 22. Name and Address of Facility 21. Sign fore of Funeral Service Licensee Sonal S. W State Anatomy Board 655 W. Baltimore Street timore. Approximate Interval Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line Medical Death Pentazocine intoxication kaminer Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and Physician/Medical #1 as noted, 23a,27,28a-f, permE, g888 2/6/09 ysician a X UNPENDED The law requires that the death certificate be Box 68760. 23d. Date of delivery attending phys for use as the b 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Month Dav Live birth Fetal death past 12 months Pregnant at time of death Other (Specify) Yes 2 No 9 ✔ Unknown Unknown the 23e. Did tobacco use contribute to the cause of death? signed by 1 be detache Ö Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Yes 2 V No 3 Probably 4 Unknown ے Division of Vital Records, Completed 24a. Was an 24b. Were autopsy findings available peen autopsy prior to completion of cause of certificate has performed? death? 1 🗸 Yes 2 No ✓ Yes 2 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital Residence 6 V Other: Scene Nursing Home 5 ER/Outpatient 3 Inpatient 2 ဥ 1 V Yes No 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury Certification: Yes 2 XNo Pending Fd 12/31/08 Fd 7:58 an 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1319 Evering Ave Rosedale, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc 6 X Could not be 3 Suicide house determined Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifi

30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Margarita Korell MD. Assistant Medical Examiner State 31. Date filed (Mont

O.C.M.E.

January 1, 2009

29b. Signature and title of certifier

ma

Registra

08-09704

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Shani Jones State of Maryland / Department of Health and Mental Hygiene 2008 43195 1- For State Certificate of Death Registrar Rea. No 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 3. Time of Death Month Day December 25, 2008 Medical Examiner 0234 hrs Shani L. Jones-Abbey 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Northwest Hospital Center Randallstown **Baltimore County** 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24Hrs. | 8. Date of Birth (MM/DD/YYYY) | 9. Birthplace (State or Foreign Months Davs Hours Director 577-92-6808 34 Country) м 2 XF 3 - 07 - 74D.C. Usual Residence of Decedent any 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show ust be notified at once Xyes 2 D.C. Washington Funeral Director 10e. Street and Number 10g. Citizen of What Country 10f. Zip Code 3201 Warder Street, N. W. 20010 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black: If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2XXMarried Armed Forces Yes 2 X No 0. Yes, Give Yea Black Widowed Divorced Yes 2 X No specify: Specify: "natural". <u>م</u> 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th permit. Pages 1 and 2 should be filed within 72. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "injury or other traumatic event, the Medical Injury or other traumatic event, the Medical College (1-4 or 5+) MD 21215-0036 News Paper Distributor Private Industry 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Sean MCCary Brenda Jones 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21136 19a. Informant's Name/Relationship (Type, Print ) Brenda M. Jones/Mother 106 Brookebury Dr., #1-B e of Disposition (Name of cemetery, Date 2 Randellstown, MD 20b. Place of Disposition (Name of cemetery 20a. Method of Disposition 20c. Location - City or Town, State Baltimore, 1 X Burial 2 Cremation 3 crematory or other place) ∏an.6,200∮ Suitland, MD Removal from State Donation 5 Other Specify: Washington National Cem. 22 Name and Address of Facility Austin Royster Funeral Home 21. Signature of Funeral Service Licenses 3821 14th St., N.W., Washington, DC20011 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Physician failure. List only one cause on each line. Between Onset and /Medical Death Pulmonary thromboembolism Immediate Cause (Final disease kaminer or condition resulting in death) Due to (or as a consequence of) Deep vein thrombosis Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last requires that the death certificate be executed and Physician/Medical AMENDED PI line a-b, 27, per EM g887 1/27/09 TT the attending physician and for use as the burial -X UNPENDED Records, P.O. Box 68760, IE EEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Fetal death Day past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 V Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ Yes 2 No 3 Probably 4 V Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has performed? death? ✓ Yes 2 No 1 🗸 Yes No 25. Was case referred to medical To the Hospital or Attending Physician: 26.Place of Death (Check only one) Division of Vital Be examiner? Hospital: Other<sub>4</sub> Inpatient 2 V ER/Outpatient 3 DOA Residence 6 1 V Yes Nursing Home 5 After this 10 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: X Natural Pending Yes 2 24 hours after death. Funeral Director: tely filled in by the 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical within 2 To the F 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. OCME December 25, 2008 30. Name and address of person who completed cause of death (Item 23a)

Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001 OCME 2006

Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. N<sub>2</sub> 0 0 8 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 7:00 PM 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore NORWOOD If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours 215-28-4040 Yrs. Marylano Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-4 energy injury or other traumatic event, the Markett E. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Xyes 2 No Funeral Director altimore 10g. Citizen of What Country? 10e. Street and Number 21207 Norwood 12. Was Decedent Ever in U.S. Armed Forces? 1 Ø Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Specify: Blac 1 ☐Yes 2 ZNo. Specify: þ 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) river 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Ave Bathmore WITE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 123/08 Forest Cemetri Mills. 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign ture of Funeral Service Licenses 22. Name and Address of Ficility Howell Balto /23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Dancreaho **Physician** disease or condition resulting in death) /Medical ue to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uncertain Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Physiclan: The law requires that the death certificate be executed page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? e Husian malia pleural 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an deals autopsy performed? Ves 2 7 No 2 140 1 Yes completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home Certification: To 5 Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death To the Hospital or Attending F within 24 hours after death.
To the Funeral Director: After 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 05080 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Balto MD

State Registrar M DeMusis, MD

JAN 13 2009

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

alla

Claales 1

6565 M.

32. Registrar's Signature

	13268 Mus		on, give street ai Drive	na nambor)			Silver Spr				1	/lontgome	ry	
	5. Social Security 549-74-5		6. Sex		yrs. last birtho	lay) Yrs.		ear If Unde ays Hours	er 24Hrs.		Birth(MM/ <b>)9/19</b>		9. Birthi oreign Coun	place (State or Washington Itry) DC
į	Usual Residence	of Decedent							_					
	10a. State	10b. County		ļ	. City, Town or									10d. Inside City Limits 1 X Yes 2 No
ģ	MD	Montg	omery		Silver	Spi	ring 10f. Zip Code				10a Citi	zen of What		
Director	10e. Street and Nu	umber									109. 018			,
	13268 M	usicma		ive s Decedent Ever	ria II C. T.	10 14/0	s Decedent of	904	ain? / Snoc	ify Voc or	No. I	US 14 Page /		an Indian, Black,
neral	Marital Status     Never Marr	ried 2 N	Married Arm	ned Forces?			es, specify Out				10	White, e		an maian, black,
Fune	3 Widowed	4 <b>X</b> Di	vorced If Yes, Gi	Yes 2 X ve Year	No	1	Yes 2 X	No specify.	:			Specify: B	l ac	<b>b</b>
d b	15. Decedent's E		or Dates:		ed) 16a. De	eceden	t's Usual Occu	cation (Give	kind of wor	k done		Kind of Busin		
Completed	Elementary/Sec	condary (0-12	Colle	ege (1-4 or 5+)	du	iring m	ost of working	lite. DO NO I	use retired	1)				
ם				3	Adn	ini	strato		icer				Go	verment
	17. Father's Name								r's Name (F		e, Maiden	Surname)		
o Be	Carlyle		AcAdams	4.)	106	Moiline	g Address (St		e Ma		Curne		State	Zin Codo)
ř	19a. Informant's N			·			,							
	20a. Method of Di		ns - Rro	otner			Claudin sition (Name of			Wast Date		Location - C		
	1 X Burial 2		on 3 Remo	oval from State		,	her place)							100
- 1		5 Other S			Ft. Li		1n Cem							
	21 Signature of F	1		Jan-										ome, Inc.
	23a. Par I. Enter	the diease	1- Chul	that caused the	death Do not	enter t	01 Blac	no. such as	cardiac or r	espiratory	arrest, sh	ock, or heart	י עוד	Approximate Interva
			e on each line.											Between Onset and Death
	Immediate Cause or condition result			ertensiv oras a conseque		ros	clerot	ic car	diova	scula	ar di	sease	_	
			b.	71 do a conce <b>q</b> a e	51100 017.									
Jer	Sequentially list of if any, leading to it	immediate		or as a conseque	ence of):									
Examine	cause. Enter Und (Disease or injury	that initiated	G. Dura to 7	or as a conseque	ence of):				_				_	
Ě	events resulting in	n death) Last	d Dae to (c	71 a3 a conseque	Silice Oily.									
dical	X UNPENDE	:D	AMEN	<sub>DED</sub> 23a,2	27,perm	E,	G887 1,	/15/09	TT'					
Ned	IF FEMALE:		23c. l	f yes, outcome o	of pregnancy					•	23	d. Date of de	elivery	
hysician/Me	23b. Was deceder past 12 month		the 1	Live birth	2	Fe	etal death	3 Ectop	ic pregnan	СУ		Month	Da	ay Year
sici	1 Yes 2	_	-1	Pregnant at time	e of death 5	01	ther (Specify)							
hy	Part II. Other sign		3		it not resulting	in the I	underlying caus	se given in F	Part I.	23e. Di	d tobacco	use contribu	ute to ti	ne cause of death?
by	r art ii. Other sign	milicani cono	itions continue	ating to death be	it not resouring		ondonying sou	oo giron iii				_		ably 4 V Unknown
ted		<u></u>								1 24a. W	as an	1 24b. We	ere aut	opsy findings available
ompleted	<u> </u>					_	<u> </u>			au	topsy rformed?	pri		empletion of cause of
										1 🗸 Ye			✓ Yes	2 No
Se C	25. Was case reference examiner?	erred to medic					26.P	lace of Death	n (Check or	ily one)				
o B	1 Yes	2 No	Hospital:	i inpatient		·		Other <sub>4</sub>		Home 5		ence 6 🗸		Scene
'n.	27. Manner of De			. Date of Injury (Month, Day, Year)		ime of	Injury 28c.	Injury at Wor		8d. Descri	be how in	jury occurred	3	
atio	2 Accident		nding estigation				1.	Yes 2						
iffic	3 Suicide	6 Co	uld not be 286	e. Place of Injury	- At home, far	m, stre	et, factory, offi	ce building, e	etc. 2		n (Street n, State)	and Number	or Rur	al Route Number, City
Certification:	4 Homicide	=	1	pecify)										
	29a. Certifier (Check only	Certifying	Physician: Tot	he best of my kn basis of examina	nowledge, dear	th occu	irred at the time	e, date and p	lace, and d	ue to the c	ause(s) a	nd manner a	s state	d. cause(s)
Medical			and ma	basis of examina inner stated.	ation and/or in	v <del>e</del> sii98				are arrie, de				
Σ	29b. Signature ar	nd title of certi	fier /	1				ense numbe	er .			_		th, Day, Year)
	16/1	in Bi	andl.	MY			0.	.C.M.E.			De	cember 2	2, 20	UO
	30. Name and ad									1001				
	Melissa Br			it Medical Ex		111 F	Penn Street	t, Baltimo	re, MD 2	1201				
tate trar			2009	32 Registrar's S	Signature	la o.	Kal							
4 4-11	4	4 FM H												

**ORIGINAL** 

1217 hrs

State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 1:35 AM M December Mary Jane McCarthy 14, 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Brooke Grove Nursing Home Sandy Spring If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year, Mar 5, 192 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1921 87 Ohio Director 217-18-6940 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mantal Hygiene.
Importent: If item 27 is marked other then "natural", or items 23a or 28a-f show eny injury or other treumatic evant, the Medical Examinations or other treumatic evant, the Medical Examination of the control 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location MD Montgomery 1 ☐ Yes 2√☐ No Director Sandy Spring 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1614 Hickory Knoll Road 20860 <u>USA</u> Completed by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify: Specify: white 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) administrator personnel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Francis Joseph Xavier Hamill Marie Andrews 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maureen Salvail/daughter 3712 King William Drive Olney, MD 20832 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State \*4 X Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Romald S. Ward 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street ma 21201 Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Oause (Final disease or condition resulting in death) PNEUMONIA **Physician** 48 HOWES /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner sate has baan signed by the attending physician and page 2 should be detachad for use as the burial-transit The law requiras that the death cartificata be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Completed by Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ALZHEIMER 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? this certificate 1 ☐ Yes 2. No filled in by the funeral diractor, 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Other 4KI Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☑ No 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred after death. 27. Manner of Death 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide To the Hospitel o. within 24 hours aft To the Funaral Di Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 33700 Tannary 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WILLIAMSPORT 154 N. ARTIZAN led E. Hour MD 31. Date filed (Month, Day, Year). 32 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

			For State Registrar	State	of Maryla	•	rtment of F		d Mental Hy	rgiene Reg. No. 200	8 43199
			Decedent's Name (First, Middle)	e, Last)					2. Date of De	eath	3. Time of Death
	Physicia		Robert McDani	iel					Month Decemb	Day Ye	B.A
	/Medic Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death							4c. County of D	
	LXaiiiii	Ç'	Holy Cross H	Hospital			Silver	Spring		Montgo	merv
	Funeral		Social Security Number	6. Sex		s. last birthday)	If Under 1 Year Months Days	If Under 24 l	Hrs. 8. Date of Bir Min. (Month, Da	rth 9.	Birthplace (State or Foreign Country)
	Director		257-28-7392	1∭7 M 2□ F	82	Yrs.	Months Days	Hours	July 2	. 1001	Georgia
	D.		Usual Residence of Decedent		1.0						40d Indid Challente
	arylar show	_	10a. State unk 10b. County		unk   10c. (	City, Town or Loc	cation			unl	t 10d. Inside City Limits unk
	8a-f	Director									
	ith th	Ë	10e. Street and Number			unk	10f. Zip Code		unk	10g. Citizen of What	
	ath v	ra		10.111					0.40	US	
	hours after death with the Maryland tural", or items 23a or 28a-f show al Evaning must be notified at	Funeral	11. Marital Status	Armed	ecedent Ever in Forces? s 2   No	U.S. 13. V	Yas Decedent of F Yes, specify Cub	an, Mexican, Pu	? (Specify Ye's or No uerto Rican, etc.)		American Indian, Vhite, etc.
36	s aft	by F	1 ☐ Never Married 2 ☐ Marr 3 ☐ Widowed 4 ☐ ☑ Divorced	If Yes		-50	□Yes 2XNo	Specify:		Specify:	white
21215-0036	hour ttural			nt's Education	54.00.	16a. Deced	lent's Usual Occup	oation		16b. Kind of Busine	ess/Industry
SE:	ld be filed within 72 lental Hygiene. Ked other than "nat itc event, Ir. W. Jin	Completed	(Specify only highe	st grade complete	d) (1-4or 5+)	(Give	kind of work done OO NOT use retire	during most of	working	Ì	
717	with jiene r tha	E	Elementary/Secondary (0-12) 1 2	4	(1-401 5+)		engine	eer		build	linos
ᅙ	filed Il Hyg othe vent,	Be C	17. Father's Name (First, Middle,	Last)					Name (First, Middle	e, Maiden Surname)	
<u>a</u>	S should be filed within 72 hours after death with the Marylan and Mental Hygiene.  Is marked other than "natural", or items 23a or 28a-f show aumatic event, it is No lice Exprise must be notified a	10 B	J. C. McDanie	21				M.	ary E. St	one	
ar S	shou and N s mar		19a. Informant's Name/Relations	ship (Type. Print)		19b. Mailin	g Address (Street	and Number o	or Rural Route Numb	per, City or Town, Sta	te, Zip Code)
Ĕ	alth a		Jack Strickla	ind/frien	d	46729	9 Manches	ster Te	rrace Pot	omac Fall,	VA 20165
Baltimore, Maryland	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any injury or other traumatic es once.		20a. Method of Disposition		20b	. Place of Dispos cemetery, cren	sition (Name of natory or other pla	ce)	Date	20c. Location - City	or Town, State
Ĕ	Page nent o		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 📉 Other (S	3 ⊔Removal fro <i>Specify)</i> in S	m State						
ᆵ	mit. partm porta / inju		21. Signature Peneral Service		and the second second	22	Name and Addre	ess of Facility	and 655 U	. Baltimor	o Charat
ñ	B E E B		MANA	s. wade,	WEZ		ltimore,			. Baltimor	e Street
			23a. Part 1. Enter the disease, or shock, or heart failure. List	complications the	t caused the de	ath. Do not ent	er the mode of dyi	ng, such as car	rdiac or respiratory a	arrest,	Approximate Interval Between
9	Physician	1 1	Immediate Cause (Final disease or condition	only one cause of		orrhage	stroke				Onset and Death
,	/Medical		resulting in death)	a. Due	to (or as a conse						
	Examiner		0	h							-62
	D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due	to (or as a conse	equence of):					
	nd nd ransi	Examiner	Cause (Disease or injury that initiated events	с							
Ö	e exe ian a urial-1	Ä	resulting in death) Last	Due	to (or as a conse	equence of):					
8760,	ficate be executed physician and s the burial-transit	dical		d							
9	ertific ling p e as t	Mec	IF FEMALE:								
Box	death certific e attending p d for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 □ Li	outcome of preg e birth 2 2 Fe	etal death 3	Ectopic pregnanc	су		23d. Date of Month	f delivery  Day  Year
0	0 0	sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		egnant at time o known	of death 5 L	Other (specify) _				,
o.	The law requires that the drate has been signed by the page 2 should be detached	Phy	Part II. Other significant conditi	ons contributing to	death but not re	esulting in the ur	derlying cause giv	ven in Part I	23e. Did	tobacco use contribut	te to the cause of death?
Š,	ires tl signe	by	hypertension		death but not n	osalang in the di	lucilying cadoo gr	vori in r di c i.			Probably 4☐Unknown
0	requi	eted	пурстесныхон			_					
Vital Records,	E SI CI	Completed							— 24a. Was	ppsy prior	e autopsy findings available r to completion of cause of
=	sician: The la certificate ha rector, page 2	Cor							1 □Yes	ormed? deat	Yes 2 □No
<u> </u>	sician: certific irector,	Be	25. Was case referred to medica examiner?	Hoonital:			041		Death (Check only	one)	
<del>-</del>	his b	၉	1 Yes 2 Mio		-	☐ ER/Outpatier 28b. Time of	I 3 DOA			sidence 6 Other (	Specify)
Ä	ling I After funer	io	27. Manner of Death 1 ☑ Natural 5 ☐ Pendir	ng (M	ite of Injury Jonth, Day, Year)		Wor	rk? ]Yes 2∐No		how injury occurred	
<u>S</u>	ttend death tor: the 1	icat	2 ☐ Accident investi 3 ☐ Suicide 6 ☐ Could	not be	on of Injury - At	home form etr	eet, factory, office	Tes ZLINO		(Street and Number of	or Rural Route Number,
Division of	or A	Certification:	4 ☐ Homicide determ	nined 206. Fig	ilding, etc. (Spe	cify)	set, lactory, office		City or To	wn, State)	r narai noate wamber,
_	pital burs a eral l		29a, Certifier 1 Certifyii	na Physician: To	the hest of my k	nowledge deat	occurred at the t	ime date and r	place and due to the	e cause(s) and manne	er as stated
	24 hc 24 hc Fun etely	Medical		Examiner: On th						, date and place, and	
	To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director. After completely filled in by the funera	Me	29b. Signature and title propriifie			. ^	29c. Licens	se number		29d. Date signed (M	fonth, Day, Year)
	F > F 0			MMXI	us l	MI	D63	579		Dec 31,	2008
7			30. Name and address of person	who completed o	ause of death (It	tem 23a) (Tyne	Print)				
			Maria Jer			Holy C:		lverSpr	ing ,MD		
	Sta	te	31. Date filed (Month, Day, Year)	) 32		nature par					
	Registr	ar	JAN 132	1009 Ale	is the f	. Apar					

08-09538 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Charles McBride 43200 2008 1- For State Certificate of Death Reg. No Registrar

1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day December 19, 2008 0936 hrs **Medical Examiner** <u>Charles McBride</u> 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Baltimore** Johns Hopkins Hospital 5. Social Security Numberunk If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In vrs. last birthday) 6. Sex **Funeral** <sup>reign</sup> North <sup>Country)</sup>Carolina Foreign Months Days Hours Aug 4, 1954 Director 1 X M 2 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1) Yes 2 No Baltimore MD , or items 23a or 28a-f shor must be notified at once. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21216 USA 413 Aisquith Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Funeral 11. Marital Status Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc permit. Pages 1 and 2 should be filed within 72 hours after death \text{Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or item injury or other traumanite event, the Medical Examiner must b 1 X Never Married 2 Armed Forces? Married 2 X No Yes f Yes, Give Year 1 Yes 2 X No specify: Specify: black Divorced Widowed þ 16a. Decedent's Usual Occupation (Give kind of work done un 2 16b. Kind of Business/Industry unk 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) timore, MD 21215-0036 unk 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unk unk Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) 110 N. Central Avenue #219 Baltimore, MD Juanita Brockington/aunt 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) Burial 2 Cremation in X Other Specify. state Donation 5 State Anatomy Board 655 W. Baltimore Street Baltimore MD 21201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line. /Medical Death Hypothermia complicating cirrhosis of the liver Immediate Cause (Final disease **xaminer** or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last Physician/Medical 23a,27,28a-f, perME, XUNPENDED Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Month Year 3 Ectopic pregnancy Day Live birth Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown 9 Unknown þ

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit Medical Certification: To Be Completed by Physician/Medical Exan

Part II. Other significant conditions of	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ✔ Unknown
		24a. Was an autopsy findings available prior to completion of cause of death?  1  Yes 2 No 1  Yes 2 No
25. Was case referred to medical	26.Place of Death (Check	only one)
examiner? 1 ✓ Yes 2 No	spital: 1 Inpatient 2 🗸 ER/Outpatient 3 DOA Other 4 Nursi	ng Home 5 Residence 6 Other:
27. Manner of Death  1 Natural 5 Pending 2 V Accident Investigation	28a. Date of Injury (Month, Day, Year)  FD 12/19/08 FD 9:00 am 1 Yes 2 X No	28d. Describe how injury occurred subject exposed to cold environmental temperature
2 X Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (Street and Number or Rural Route Number, City or Town, State) 413 Aisquith St Baltimore, MD
(Crieck Only	a: To the best of my knowledge, death occurred at the time, date and place, an	

29c. License number

O.C.M.E

111 Penn Street, Baltimore, MD 21201

DHMH 17 Rev 1/2001 OCME 2006

State Registrar and manner stated

Assistant Medical Examiner

30. Name and address of person who completed cause of death (Item 23a)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Pamela E. Southall, MD

29d. Date signed (Month, Day, Year)

December 20, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 25 per me 8887,01/23/09dhb

Amend Items 23art1,26 per dr., 8887,01/12/09dhb Department of Health and Mental Hygiene 0 0 8 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 11:04 AM December awrance 2008 /Medical Facility Name (If not institution, give street and num 4b. City, Town, or Location of Death County of Death Examiner Burnie Under 24 Hrs. 1 rough timore If Under 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Social Security Numberunk 7. Age (In yrs. last birthday) **Funeral** Year) Months Days Hours 1 M 2□ F Yrs. Director 66 <u>J</u>an 1, 1942 Maryland Usual Residence of Decedent be filed within 72 hours after death with the Maryland nital Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Even instruct be notified at Director MD 1 ☐ Yes 27 No Howard Jessup 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Jessup House of Correction 20723 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify. Specify: black Completed by 3 Nidowed 4 Divorced "natural", Pages 1 and 2 should be filed within 72 ho ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natur ury or other traumatic event, I'm Medical. 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk unk (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Wallace McCoy ဥ Evelyn maddox 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Juanita Chase/sister 3702 Seven Mile lane #T2 Baltimore,MD 21208 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Department of Important: If it any Injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5፟\(\Delta\)Other (Specify) in state 21. Signature of Juneral Service Licensee Wade, State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause an each line.

Immediate Cause (Final Approximate Interval Between Onset and Death **Physician** MED ALEXAM ED ALEXAM disease or condition resulting in death) /Medical Due (or as a consequence of) Examiner Aspiration Pneumonía 5 days Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of, The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): CERTIF P.O. Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 Live birth 2 Fetal death 3 🗆 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) detached 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown cate has been signed by i page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 No 3 Probably 4 Unknown certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 ☐ Yes 1 ☐ Yes 2 ☐ No of Vital Physician: 25. Was case referred to medical examiner?

1 X Yes 2 A Ho Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) Hospital: Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification; To this within 24 hours after death.

To the Funeral Director: After th
completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred the Hospital or Attending Division 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral C TX CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. npleted cause of death (Item 23a) (Type, Print) 1 22. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 43202 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 12:26pM James Pinkard 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Takoma Park Montgomery 5. Social Security Number Adventist Hospita 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 66 | Yrs | Months | Days | Hours | Min. | Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 X M 2 □ F 226-54-4706 26, D. Director Jan. 1942 C Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Wedical Error instruction milling at Director D.C. Washington 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 617 Dahlia Street, N.W. 20012 Funeral and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Day Program Day Program Special Ed. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Carroll Pinkard Catherine Smith ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Washington, DC 20005 (DDS Service Beverly Jackman 1125 15th Street, N.W. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition Date Department of H Important: If ite any injury or ot once. 1 □ XBurial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Mt. Zion Cemetery 01/08/2009 Baltimore, Md. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility W. H. Bacon Funeral Home, Inc. 3447 14th Street, N.W. Washington, DC 20010 20361 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Cardiar Arrythmia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after ceath.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Rena Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performs 1 □Yes 2 1000 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \( \text{(Specify)} \) 21410 1 Inpatient ၉ 1 ☐ Yes 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Certification: 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 65183 12/19/2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Liang Avenue Idai ying Liau
31. Date filed (Month, Day, Year) 600 arrol 22. Registrar's Signature State JAN 4 Registrar

State of Maryland / Department of Health and Mental Hygiene? 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 12/30/2008 **Physician** 1:55 P M Lorine Shara Peters /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Greater Baltimore Medical Cen. Towson If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) Social Security Number **Funeral** Days Hours 1 □ M 2 🗷 F 46 212-94-0938 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a, State show Baltimore Towson 1 ☐ Yes 2 No MD iral", or items 23a or 28a-f sh Exa⊞lner must be notified Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 500 Virginia Ave. Apt. 306 21286 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 72 hours after 1 ☐ Yes 2 ☑ o If Yes, Give Year or Dates: 1 Never Married 2 Married Black 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify þ 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) other traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) be filed within 7 al Hygiene. Never Worked College (1-4or 5+) Never Worked 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 12 should be find and Mental Find Mental F George Calvin Peters, Sr. Rosetta Thompson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 616 N. Avondale Rd. Dundalk, MD 21222 permit. Pages 1 and 2 Department of Health a Important; If item 27 is any injury or other trau once. Rosetta Shoulders/Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Jañ". 1₺ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, MD Mt. Carmel Cem. 2009 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facil®AFA/Stephen D.Lohrmann P.A. 21. Signature of Funeral Service Licensee M01443 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 8717 Green Pastures Dr. Balti. MD 21286 Physician Metastatic cancer disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Division or Vital Records, P.O. Box 68760, Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached 9 I Inknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 9 1 Tyes 2 No 3 Probably 4 Munknown Pulmonary edema and congestion Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☑Yes 2 ☐ No autopsy performed' 1⊠Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

Hospital or Attending Physician: s after death.

I Director: Af within 24 hours after dear to the Funeral Directo completely filled in by the

> State Registrar

4 Homicide

29b. Signature and title of certifier

29a. Certifier (Check only one)

Robert A. Palermo, 6701 N Charles Street, Baltimore, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) JAN 1 3 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

- hm

1 Crifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D27740

29d. Date signed (Month, Day, Year)

01-13-2009

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2008

			1 - State Registrar		Ce	rtificate of	Death		Reg. No	2008	43204
П	Discolois		1. Decedent's Name (First, Middle, Last)					2. Date of De	eath Day	y Year	3. Time of Death
	Physicia /Medic		Charles Eugene	e Riddick				Decemb		21,2008	12:57
	Examin		4a. Facility Name (If not institution, give	street and number)			or Location of Deat	h	4c.	County of Death	
-			4802 Maui Stre			Clin	ton If Under 24 Hrs	T 0 D-1 ( D)	Pr	rince G	eorges
	Funeral		5. Social Security Number 6. Sex	7M 2DE	st birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	(Month, Da	rth ay, Year)	9. Birthr	
١,	Director		212-72-3598 Usual Residence of Decedent	51				4/25/	195	/ Mar	yland
	land ow		10a. State 10b. County	10c. City,	Town or Lo	cation				1	0d. Inside City Limits
	Mary f sh	Ď	MD Prince (	Corgos		Clint	on				1 <b>X</b> Yes 2 □ No
	the 28a	Director	10e. Street and Number	Jeorges		10f. Zip Code	011		10g. Cit	izen of What Cour	ntry?
	3a or		4802 Maui Stree	<b>.</b> +		20	735			USA	
	ms 2	Funeral		12. Was Decedent Ever in U.S.	13.		Hispanic Origin? (S pan, Mexican, Puer	Specify Yes or No	)-	14. Race - Americ	
9	or ite		1 ☐Never Married 2 ☐ Married	Armed Forces? 1 ☐Yes 2 XNo				to Rican, etc.)		Black, White,	
03	hours after death with the Maryland tural", or items 23a or 28a-f show al Eval. or inst be raffled at	l by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 □Yes 2 <b>X</b> No	Specify:			Specify: B	Black
21215-0036	should be filed within 72 hours after death with the Marylan nd Mental Hygiene. marked other than "natural", or items 23a or 28a-f show imatic event, the Medical Evan, ear must be myfff of	Completed	15. Decedent's Educ (Specify only highest grade		(Give	dent's Usual Occu kind of work done	during most of wo	rkina	16b. Ki	ind of Business/Inc	dustry
2	filed within 72 Hygiene. other than "natent, the Medic	ld u	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	od)	Ü	_	S	
2	ed w lygiel lygiel lt, th	ပ္ပ		2	Tr	uck Dri	1	(First 14)-(-)		Private	
Ē	be fill	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nar			,	
<u>Ş</u>	should be tand Mental smarked oumatic eve	P_	Charles Ford F							oeth Ric	
Maryland	12 sh hand 7 is n traun		19a. Informant's Name/Relationship (Ty		19b. Mailii 1320	ng Address (Street ) 3 Stray	t and Number or R. Vberry I 2073	Įill Pl	er, City o .ace	South	Code)
e,	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		Michelle Greene 20a. Method of Disposition		CL1r	iton, Mil	$\frac{1}{20/3}$	Date		ocation - City or To	
چ	Pages nent of int: If its iry or o		1 ☐ Burial 2 🖟 Cremation 3 ☐ R	emoval from State		sition (Name of natory or other pla					
Baltimore,	it. Partme		4 Donation 5 Other (Specify)				atory 1/			erdale,	MD eral Home
Ba	permit. Pages Department of Important: If it any injury or once.		21. Signature of Funeral Service License	e e							eral Home n,DC20011
ı			23a. Part 1. Enter the disease, or compli shock of heart failure. List only or	ne cause on each tine							Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Arteriose	Pero	Too the	nerta	sine,	Hea	I Dis	Onset and Death
	/Medical		resulting in death)	Due to (or as a conseque	nce of):	7			-		
	Examiner	_	Sequentially list conditions,	)							
	pe sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conseque	nce of):						
	ecut and trans	хаш	that initiated events resulting in death) Last	Due to (or as a conseque	nce of:						
68760,	The law requires that the death certificate be executed ate has been signed by the attending physician and age 2 should be detached for use as the burial-transit			Dao to (or do a correcção	1100 017.						
587	ficate phys s the	Medical		l							
ŏ	certii nding ise a		IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnance	су					23d. Date of delive	erv
ň	Jeath atte	cial	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal d 4 ☐ Pregnant at time of dea	leath 3L	☐ Ectopic pregnand ☐ Other (specify) _	су			Month	Day Year
<u>Ч</u>	the cy by the	hysi	9 Unknown	9 ☐ Unknown							
~, T	s that ined be deta	by Physician	Part II. Other significant conditions cor	ntributing to death but not resulti	ing in the u	nderlying cause gi	ven in Part I.	23e. Did t	tobacco u	use contribute to the	ne cause of death?
Records,	quire en sig uld b							1 🗆	Yes 2	□ No 3□ Prob	pably 4 Unknown
ပ္က	as bee	Completed						24a. Was		24b. Were auto	psy findings available
ř	The I	mo						autoj perfo 1 □Yes	psy ormed? 2.☑No	death?	mpletion of cause of
Vital		Be C	25. Was case referred to medical				26. Place of De	ath (Check only o		1 10103	2 1110
	Physician: r this certific ral director,	<b>To E</b>	examine? 1  Yes 2  No	lospital: 1 ☐ Inpatient 2 ☐ El	R/Outpatie	nt 3 DOA Oti	her: 4  Nursing F	lome 5. Resi	idence	6 ☐Other (Specif	'y)
0	utending Physideath.	uc:	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day, Year)	8b. Time o	f 28c. Inju Wo	ry at rk?	28d. Describe	how injur	ry occurred	
Ö	Attendir death. ctor: A y the fu	atic	2 Accident investigation				]Yes 2 □No				
Division of	42 . 2 2	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, str	eet, factory, office		28f. Location ( City or To	Street an wn, State	nd Number or Rura e)	l Route Number,
	pital o		29a. Certifier 1 Certifying Phys	sician: To the best of my knowl	ledge, deat	h occurred at the t	time, date and place	e. and due to the	cause(s	and manner as s	stated.
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Medical		ner: On the basis of examination and manner stated.							
	To t To t	Σ	29b. Signature and title of certifier	11 -1	2	29c. Licen	se number		29d. Da	te signed (Month,	Day, Year)
	~		Monda	12/200	5	H	20559	7-/	In	sung	7,2008
1	7		30. Name and address of person who co	1 -	23a) (Type,	Print)	1 200	10 1	6	- 0 1	
0	-0:		31. Date filed (Month, Day, Year)	32. Registrar's Signatur	7 /7	75/1/a	1011	Le J	7	7	1. June
	Sta		Date into (month, buy, rear)	January Orgitatu	, ,					-	

ORIGINAL

DHMH 17 Rev 1/2001

8-09781		Please Type or Print in Black Indeli State of Maryland / Departme	ble Ink. Ensure All Copie	s Are Legi vaiene	ible.		
lary Margaret Ro		State of Maryland / Departing	ate of Death		. No. 200	8 4320	
Dhusisis	R	egistrar . Decedent's Name (First, Middle,Last)	*	2. Date of Death	3	3. Time of Death	
Physicia Medical Examir		Mary Margaret Roth		Month December 2		0950 hrs	
		la. Facility Name (if not institution, give street and number) 1306 Potomac Avenue Apt. 12	4b. City, Town, or Location of Death Hagerstown		4c. County of Death Washington	4	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last bird		8. Date of Birth	(MM/DD/YYYY) 9. Birth Cour	place (State or Foreign	
Director	L	188-38-8677 <sub>1 M 2 XF</sub> 57	Yrs. Months Days Hours Min.	Aug 1,		nsylvania	
v any		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town				10d. Inside City Limits  1 Yes 2 No	
fand f shov	힏		agerstown 10f. Zip Code	100	g. Citizen of What Count	21	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Fleath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once	Director	10e. Street and Number 1306 Potomac Avenue #12	21740		USA		
with us 23;	la l	11. Marital Status  12. Was Decedent Ever in U.S.  Armed Forces?	13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	. 14. Race - Americ White, etc.	an Indian, Black,	
death or iten	Funeral	1 Yes 2 X No			Specify: wh	ite	
ral",	à	3 Widowed 4 X Divorced If Yes, Give Year or Dates:	1 Yes 2 X No specify:  Decedent's Usual Occupation (Give kind of v	work done			
hours 'natur		15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)	during most of working life. DO NOT use reti	red)		gire v i s	
36 nin 72 e. Ithan '	릚	12 3		2 1	customer s	ervice	
d with	Completed	17. Father's Name (First, Middle, Last)	18.Mother's Name	e (First, Middle, M	laiden Surname)		
215 be file ntal H rked c	Be (	John T. Ginkinger		et E. Ha			
21 nould d Mei is mai	의	Tod: Information (Table)	b. Mailing Address (Street and Number or			Zip Code)	
MD d 2 sh Ith an n 27 i			1520 Iris Court Hages of Disposition (Name of cemetery,	Date	MD 21740 20c. Location - City or	Town, State	
s l an of Hea If iter		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  20b. Place crema	atory or other place)				
Page nent o	Ц	4 X Donation 5 Other Specify:					
Balt permit. Departu Import injury		21. Signat e c uneral Service I censee Wade, Wade tor	State Anatomy Boar	d 655 W.	. Baltimore		
Physician /Medical		23a. Part I. Inter the disease, comment in shat caused the death. Do failure. List only one cause on each line.			est, shock, or heart	Approximate Interval Between Onset and Death	
taminer	3 (4	Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	erosclerotic Cardiovascular Diseas	36			
		h					
	Je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause					
	Examine	(Disease or injury that initiated					
uted Id ansit	Ë	events resulting in death) Last  Due to (of as a consequence of).  d.					
executed ian and ial - transi	lical	UNPENDED X AMENDED 27, 28a-	f, per ME, G887 1/27	/09 TT			
Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be executed Yah hours after death or Attending Physician and Finneral Director: After this certificate has been signed by the attending physician and etely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Physician/Medi	IF FEMALE: 23c. If yes, outcome of pregnance			23d. Date of delivery  Month	/ Day Year	
687 certific nding	ian/	23b. Was decedent pregnant in the past 12 months?	Fetal death 3 Ectopic pregr	апсу	Month	Jay Tour	
SOX leath of e atter for us	ysic	1 Yes 2 No 9 V Unknown	J Utile: (Opecity)				
D. E t the c by th ached		Part II. Other significant conditions contributing to death but not result	ing in the underlying cause given in Part I.	23e. Did to	obacco use contribute to		
P.O.	d by	Multiple Sclerosis		1 Yes		pably 4 V Unknown	
Division of Vital Records, tat or Attending Physician: The law requirers after death.  "In Director: After this certificate has been sited in by the funeral director, page 2 should be the funeral director, page 2 should be a should be	Completed			24a. Was autop	osy prior to d	itopsy findings available completion of cause of	
e law e has ge 2 s	Ē			perfo 1 <b>✓</b> Yes	rmed? death? 2No 1 ✓ Ye	es 2 No	
a: Th tifical or, pay		25. Was case referred to medical	26.Place of Death (Chec	k only one)			
/ital siciar is cer lirecto	o Be	ovaminor?	Outpatient 3 DOA Other Nurs	sing Home 5	Residence 6 Othe	r: Scene	
of \oldsymbol{Of} \left g Plny fiter the neral of the second contracts of the second contract of the second contracts of the second contract of the second co	⊢		b. Time of Injury 28c. Injury at Work?	I .	how injury occurred		
on cadin ath.	<u></u> 할	Pending 12/28/2008 u	nk 1 Yes 2 X No	_	ct drowned i		
VISI or Att ter de birect in by	<u>:</u>	2 XAccident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home	, farm, street, factory, office building, etc.	28f. Location ( or Town,	Street and Number or Ri State). 1306 Pot L. Hagerstov	ural Route Number, City	
Disal of the strain of the str	Certification:	4 Homicide determined (Specify) house					
To the Hosp within 24 ho To the Func completely f	Medical C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, (Check only one) 2 ✓ Medical Examiner:On the basis of examination and/o	death occurred at the time, date and place, ar or investigation, in my opinion, death occurred	nd due to the caus d at the time, date	se(s) and manner as state and place, and due to the	ted. ne cause(s)	
To 1 With To 1	Med	and manner stated.  29b. Signature and title of certifier	29c. License number		29d. Date signed (Mo		
	-	another	O.C.M.E.		December 29, 2	800	
		30. Name and address of person who completed cause of death (Item 23:	a) 1 Penn Street, Baltimore, MD 212	01			
		7 11 12 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		-	<del></del>		
S Regi:	tate	31. Date filed (Month, Day, Year)  JAN 1 2 2009  Registrar's Signature	parker				
Kegi	માહ	7	/				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** December 9, 2008 8:01 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Baltimore Manor Care Rossville 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday **Funeral** 1 □ M 2 🛛 F 92 Jan 20, Maryland Director 215-09-1986 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be flied within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Extr. if at must be notified at once. 1 ☐ Yes 2√☐ No MD Baltimore Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1801 Wentworth Road 21234 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ∐Yes 212 No Specify. Specify: white Completed by 3 ☐ Widowed 4 ☑ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) self employed foos industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Stanislaw Borowicz Sophia Skowron ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Wancewicz/daughter 9104 Sandra Park Road Perry Hall, MD 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4∏Donation 5 ☐Other (Specify) 22. Name and Address of Facility 21. Signature Juneral Service Licensee S. Wade State Anatomy Board 655 W. Baltimore Street non Baltimore, MĎ 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Cerob ru vaise /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infiniteliate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examine Hospital or Attending Physician: The law requires that the death certificate be executed monon burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician the attending pl for use as t IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year ☐ Pregnant at time of death 5 Other (specify) 9 Unknown s been signed be should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an certificate has b rector, page 2 sl autopsy performed? 1 Yes 2 100 director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation ours after death.

neral Director: Af
filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hour To the Funer completely file Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MD D 31414

State Registrar EUTAW

12

302

BALCIMORE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

191)

32. Registrar's

HASHM

Amend Item 23a per dr., g887, 01/12/09dhb Certificate of Death Reg. No. For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 5:30 P.™ Thomas Sawyer December 28, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3016 Indiana Avenue Baltimore Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Months Days Hours 57 212 56 5040 Maryland Director 03/07/1951 Usual Residence of Decedent death with the Maryland i show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director Baltimore 1 ☐ Yes 2 No Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3016 Indiana Avenue 21227 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any Injury or other traumatic event, the Medical Exercitive once. Black, White, etc. Almed Folces:
1 1⊠Yes 2 □ No
If Yes, Give
Year or Dates: Viet Nam 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify þ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Self Employed Truck Driver Trucking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edwin Sawyer Helen M. Wissmann ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lynn Sawyer / Wife 3016 Indiana Avenue Baltimore, Maryland 21227 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bayview Crematory 01/05/2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 mus ramerous 232. Part 1. Enter the disease, or conshock, or heart failure. List only plications that caused the death. one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** lears /Medical sequence of): Examiner Hepatitis Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of)  $\eta \mathcal{Z}\mathcal{L}$ Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical as the use If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery signed by the atter 3 🗆 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes To the Hospital or Attending Physician: Within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DDA Certification: To completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Natural 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No Accident 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 405 Frederick Road Patrick White MD Baltimore, Maryland 21228 31. Date filed (Month, Day, Year) State Darke Registrar

State of Maryland / Department of Health and Mental Hygien 🤊 🛭 🕦 🖇 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Yea **Physician** 31 1335 M Drew Farnum Steis 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death . 4a. Facility Name (If not institution, give street and number) Examiner HICIMICA SALISBUM REGIONAL MODIEN TENINSULA If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Numbe Age (In yrs. 8. Date of Birth (Month, Day, Year) **Funeral** Days 70 Yrs 283-32-1689 Feb 1939 14, Florida Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ▼ No Director Westover MD Somerset the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe Pages 1 and 2 should be filed within 72 hours after death with 21871 USA 25638 Frenchtown Road Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1 Øyes 2 □ No
If Yes, Give
Year or Dates: 156-64 Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: White Completed by 3 ☐ Widowed 4 X Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, Item once. Elementary/Secondary (0-12) 5+ <u>writer</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Burton Steis Myrtle Louise Lewis ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Alex Steis/son 409 Madison Street Herndon, VA 20170 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 XDonation 5 ☐ Other (Specify) 22. Name and Address of Facility State Anatomy Board Baltimore, MD 21201 21. Signature of Furreral Service Licen Wade Director 655 W. Baltimore Street Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physiclan: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No certificate has been signed by the a rector, page 2 should be detached it 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ ☐ No 24a. Was an Was a... autopsy performed? Ves 2,500 1 □Yes 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No 2 ER/Outpatient 3 ☐ DOA ٩ 1 Inpatient this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No after death.

I Director: A
d in by the fu 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Methal Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature 09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21801 100 Surde E Carroll nris 100 32. Registrar's Signature 31. Date filed (Month, Day, State JAN 1 2 2009 Registrar

State of Maryland / Department of Health and Mental Hygien 9 0 0 8

4	3	2	0	(

**Physician** /Medical

29d. Date signed (Month, Day, Year)

Examiner

**Funeral** Director

28a-f show ò 23a

other traumatic event, the Medical Evan, increment by notified at Pages 1 and 2 should be filed within 72 hours after and to Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or ite and Mental Hygiene. Department of Important: If its any Injury or o once.

Box 68760. P.O. Division of Vital Records, After

Baltimore, Maryland 21215-0036 **Physician** /Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed signed by funeral ours after death.

neral Director: A
filled in by the ft death. within 24 hours a

For State Registrar Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 13,2008 Manuel 1 Tchiyuka December 10:00 a<sup>M</sup> 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 4924 Water Grove Lane Ellicott City Howard If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, **09/12/1938** 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) Months Days Hours Min. 1 XM 2 ☐ F 70 125-44-2299 Africa Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a State MD Howard Ellicott City 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21043 Portuga1 4924 Water Grove Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 No **Black** If Yes, Give Year or Dates Specify ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Marketing Consultant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Amelia Elumbo Barbosa Musuta ျ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4924 Water Grove Lane, Ellicott City,MD 21043 Evelyn Tchiyuka/spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility State Anatomy Board, Baltimore Street, Baltimore, MD 21201 per DVR 655 W. 21. Signature of Funeral Service Licensee Ronald S. Wade, Director Approximate Interval Between Onset and Death 1993–12/2008 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Prostate Cancer** disease or condition resulting in death) Due to (or as a consequence of): 15 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 1 □Yes 2 □No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy 2 No 1 □ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

State Registrar

Medical

31. Date filed (Month, Day, Year)

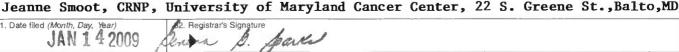
and title of certifie

4 Homicide

29a. Certifier

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

R112789

(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) Nurse Practitioner and our stated.

		•	1 - State Registrar		(	Certificate	e of D	eath		Reg. N	ю.		
			Decedent's Name (First, Middle, Last)						2. Date of D Month		ay Yee	3. Time of Death	
	Physicia		Roberta	C.	Tyson				Dec.			9:00 р м	
m.J.	/Medic Examin		4a. Facility Name (If not institution, give str	reet and number)		4b. City,	Town, or Lo	ocation of Death		4	c. County of De	ath	
	Examin	Ϋ.	Bethesda Health	& Rehabil	itation	Center	В	ethesda			Montgon	nerv	
	Funeral Director		5. Social Security Number 6. Sex 1 1 1	7. Age	(In yrs. last birth 72 y	day) If Under Months	1 Year Days	f Under 24 Hrs. Hours Min.	8. Date of B (Month, D Dec • 2	irth Pay, Yea	1936 <sup>9. 8</sup>	Sirthplace (State or Foreign Country) D. C.	
-	P _		Usual Residence of Decedent		10c. City, Town	or Location						10d. Inside City Limits	
	a-f show	ctor	D • C • 10b. County		Washi					,		1 ∑ Yes 2 □ No	
	h with the 23a or 28 at be no	ai Director	10e. Street and Number 1140 North Capit	ol Street	10.0 = 1,0 = 1					S · A ·	Country?		
920	2 should be filed within 72 hours after death with the Maryland and Mental Hyglene.  is marked other than "naturat, or ttems 23s or 28s-f show aumatic event, the Medical Examinar must be notified at	by Funerai	11. Marital Status  1 Never Married 2 Married  3 Novidowed 4 Divorced	2. Was Decedent E Armed Forces? 1 ☐ Yes 22☐ N If Yes, Give Year or Dates:		If Yes, spec	Was Decedent of Hispanic Origin? (Specif Yes, specify Cuban, Mexican, Puerto F			ecify Yes or No- Rican, etc.)		nericen Indian, hite, etc. Black	
2	72 ho	ted	15. Decedent's Educa (Specify only highest grade	ation completed)	(	Decedent's Usua Give kind of wo	rk done dui	on ring most of work	king	16b.	Kind of Busines	ss/Industry	
121	within sene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5-		life. DO NOT us House	se retired)				Self-Employed		
0 0	Hygi Hygi Sther		17. Father's Name (First, Middle, Last)				1	8. Mother's Nam	ne (First, Middi	e, Maide		-	
<u>a</u>	id be ked i	To Be	Rudolph Payne					Christ	ine But	ler			
<u> </u>	and and is m		19a. Informant's Name/Relationship (Type Geraldine Dorsey	e, Print) (Sister)		Mailing Address 26 Ho11		o Number or Rui			d. 2064		
altimore,	Pages 1 and 3 nent of Health ant: If item 27 ary or other tr		20a. Method of Disposition  1 ☐ Burial 2 TCremation 3 ☐ Re  4 ☐ Donation 5 ☐ Other (Specify)	moval from State	cemetery	Disposition (Nar , crematory or d eake Cr	ther place)	01/1	Date 12/2009		Location - City o		
Baltii	permit. Pages Department of importent: If it any injury or of		21. Signature of Funeral Service Licenses	Barn	1/21	22. Name an	Address	of Facility	ral Ho	ne,	Inc.	DC 20010	
i.	40.5 * 4		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused cause on each lin	the death. Do no	3447 1	lath S	such as cardiac	N . W .	Was arrest,	hington	Approximate Interval Between Onset and Death	
	Pnysician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a	consequence o	11/6	46	ART	FAIL	_0_1	2G	MOS	
	p W tig	cal Examiner		if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence o	f):				-		
68760,	e be exec			resulting in death) Last	Due to (or as a consequence of):  d								
	lificat g phy as th	Medical											
O. Box	ysician: The law requires that the death certificate be executed is certificate has been signed by the attending physician and director, page 2 should be detached for use as the burial-transition.	Completed by Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	ic. If yes, outcome  1 Live birth  4 Pregnant at  9 Unknown	2 Fetal death	3 □Ectopic p 5 □ Other (sp				.	23d. Date of o Month	delivery Day Year	
о <u>.</u>	that the ed by detac	F.	Part II. Other significant conditions conf	tributing to death bu	it not resulting in	the underlying	ause given	in Part I.	23e. Did	tobacc	o use contribute	to the cause of death?	
ds,	uires sign d be	d b	Bindon, OII	klood	SUM	rili!	hus	Dar Ten	a. 10	Yes	2 No 3	Probably 4 DUnknown	
of Vital Record	w req beer shou	lete			00'	- 0 9 1	01		24a. Wt		24b. Were	autopsy findings available	
Re	The law ate has b	m							pe	opsy formed:	death	to completion of cause of 1? 'es 2 \sum No	
la	ificate	e C	25. Was case referred to medical					26. Place of Dea	1 ☐ Yes		101	65 21140	
⋚	Physician: this certific ral director,	8	eyaminer?	ospital:	nt 2 EP/Out	patient 3 D	Other				6 □Other (S	pecify)	
of	J Phys ar this eral di	n: To	27. Manner of Death	28a. Date of Injur	y 28b. T		28c. Injury a Work?	at			jury occurred	,	
ion	Attending r death. ector: After by the fune	atio	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	(WOITH, Da)	7001/	M		es 2 No					
Division	or Atte after des Directo	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inju- building, etc	iry - At home, fai c. (Specify)	m, street, factor	y, office		28f. Location City or T			Rural Route Number,	
	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical C	29a. Certifier 1 Certifying Phys (Check only one)		examination and								
	To the within 2. To the complet	Me	29b. Signature and title of certifier	. 1		29	c. License	number		29d. I	Date signed (Mo	onth, Day, Year)	
	- 3 - 0		> Shuggod	Wate	Euch. 1	11)	000	5763	D	0	1/07/	2009.	
	1		30. Name and address of person who co	mpleted cause of d	eath (Item 23a) (	Type, Print)	1				_		
			10301 MEORMIA	HUG.	STEZ	09 15	1LV	FR SP	RING	M	0-20	907	
	C+	ata	31. Date filed (Month, Day, Year)	32. Registr	ar's Siggature								

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 29d per dr., 9887,01/12/09dhb
State of Maryland Department of Health and Mental Hygiens 43

Amend Items 3,26 per dr., 9887,01/07/09dhb
Certificate of Death

Reg. No.

1 - For State Registrar Reg. No. 12:53p 1. Decedent's Name (First, Middle, Last) 2. Date of Death <sup>Day</sup>6, 2008 DECEMBER **Physician** Roland Matthew Vaeth Sr. /Medical 4c. County of Death
Baltimore 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Saint Joseph Medical Center Towson 8. Date of Birth (Month, Day, Year) March 13 1914 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Hours Days Baltimore Maryland Months 1 → M 2 □ F 216 09 9967 Yrs Director Usual Residence of Decedent Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Mydical Examiner must be notified at Director 1 ☐ Yes 2 ☐ No Maryland Baltimore Baltimore County death with the 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21234 8832 Walther Blvd. USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 \( \text{Yes} \) 2 \( \text{No} \) 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2XX Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify 2 Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) N/A Elementary/Secondary (0-12) Diamond Die Cutter Western Electric 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edgar Phillip Vaeth Mary Katherine Matthes ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Roland M. Vaeth Jr (Son) 2106 Lamar Court Fallston, Maryland 21047 item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages
Department of
Important: If it
any injury or o <del>f</del>o 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State Parkwood Cemetery December 30 2008 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Lassahn Funeral Home Inc 7401 Belair Road Baltimore, Maryland 21236 2+10 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician SEPTIC SHOCK /Medical Due to (or as a consequence of): Examiner PNEUMONIA Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence of): Physician/Medical Examine burial-trans INFECTION URINARY TRACT Due to (or as a consequence of): attending physician for use as the burial サンムナンタイ Division of Vital Records, P.O. Box 68760 Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached 9 HInknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification; To 1 Yes 2 No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Avatural
2 Accident death. 1 ☐ Yes 2 ☐ No n 24 hours after death.

Reference Director: A pletely filled in by the fu 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) within 2. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier December 30, 2009 D 26002 h 30. Name and address of person who completed use of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) TOWSON MARYLAND 21204 OSLER DRIVE 601 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Manyland / Department of Health and Mental Hygiere 1008 43212

		1 - For State Registrar	State of Marylan		rtificate of			Reg. No.				
Physi	cian	Decedent's Name (First, Middle, Last)					2. Date of Dea	Day	Year	3. Time of Death		
/Med		Charles Whisma			T	-1		9	unty of Death	1:20 A M		
Exam	iner	4a. Facility Name (If not institution, giv Manor Care Rol				r Location of Deat timore	h	4c. Co	unty of Death			
-		5. Social Security Number 6. S		last birthday		If Under 24 Hrs		h	9. Birth	place (State or Foreign ntry)		
Funera Directo			XM 2□F 71	Yrs.	Months Days	Hours Min.	Nov 8,		Cou	ntry) unk		
and wo		10a. State 10b. County 10c. City, Town or Location 10d.										
Mary feb	ţ	Baltimore								1∏Yes 2□No		
death with the Maryland ms 23a or 28a-f ehow	Director	10e. Street and Number			10f. Zip Code			10g. Citizer	of What Cou	ntry?		
th wit	aiD	4669 Falls Road				1209			USA			
r dea	Funeral	11, Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13.	S. 13. Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto			- 14.	Race - Ameri Black, White,			
be filed within 72 hours after death with the Marylan trait Hyglene. Indicate than "natural", or items 23a or 28a-f ehow event, the Market Examinat and be notified at	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 24 No If Yes, Give Year or Dates:	If Yes, Give		1 ☐ Yes 2 【 No Specify:			ecify: wh	ify: white		
72 ho	eted	15. Decedent's E (Specify only highest gra		(Giv	edent's Usual Occup e kind of work done	during most of wo	rking unk	16b. Kind	of Business/Ir	ndustry unk		
of thin	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire							
e filed within at Hygiene.	Co	unk u	nk		unk	19 Mother's Na	me (First Middle	ne (First, Middle, Maiden Sumame)				
Vialiu  ould be file Mental Hy arked oth	Be		1		ulik	15. 1410(1161 5 148)	ine (i iist, iviiddie,	IVIAIUGIT SU	mamej	unk		
2 should be and Mental is marked aumatic ev	ပ	19a. Informant's Name/Relationship (	Tyne Print)	19b Mail	ing Address (Street	and Number or B	ural Route Numbe	er. City or To	own. State. Zi	p Code)		
Mal ind 2 st alth and 27 is n	1	Manor Care Rolan			Falls Ro					,		
D = 0 = 5		20a. Method of Disposition	206. 1	Place of Disp	osition (Name of ematory or other pla		Date . Fit		tion - City or T	own, State		
mit. Pages bartment of cortant: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ 1 ☐ Donation 5 ☒ Other (Special	Hemoval from State	Semetery, cre	matory or other pla							
parmit. Pages Department of t important: if its any injury or of	SUCE.		Wade Director		22. Name and Addre State Ana	ss of Facility tomy Boa	rd 655 W	. Bal	timore	Street		
		23a Part 1 Enter the disease or com	polications that caused the dea	th. Do not er	Baltimore	MD 21	201 c or respiratory a	rrest.		Approximate		
		shock, or neart failure. List only one cause on each line.  Interval Between Onset and Death Onset and Death										
Physicial /Medica	_	disease or condition resulting in death)  a										
Examine		ASGID										
	je 📕	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consec	(uence of):								
cuted nd ransit	Examiner	Cause (Disease or injury that initiated events	c									
e exe		resulting in death) Last	Due to (or as a consec	quence of):								
tificate be executed physician and as the burial-transit	edical		d									
		IF FEMALE:	23c. If yes, outcome of pregn	anov		-			1 Data - 6 da B	e nous e e e e e		
The law requires that the death cert has been signed by the attending age 2 should be detached for use a	Physician/N	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 Feta	al death 3	☐Ectopic pregnanc☐ Other (specify) _	у		230	<ol> <li>Date of delivers</li> <li>Month</li> </ol>	ory Day Year		
the de ached	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknown	Jean J	Other (specify) _							
that the de ned by the a			contributing to death but not re-	sulting in the	underlying cause gr	ven in Part I.	23e. Did t	ezu ossado	contribute to	the cause of death?		
dS, puires n sign	d by						1 🗆	Yes 2□1	No 3□Pro	bably 4 Unknown		
w requires been signatured should?	Completed						24a. Was		24b. Were aut	opsy findings available		
The law	J L						autor perfo	psy ormed? No	prior to co death? 1  Yes	ompletion of cause of		
	BeC					26. Place of De	ath (Check only o					
	5 B		Hospital: 1 Inpatient 2	] ER/Outpatio	ent 3 DOA	her: 4 🗌 Nursing i	Home 5 ☐ Resi	dence 6	Other (Spec	ify)		
On Or ding Phy After this funeral d		27. Manny of Death	28a. Date of Injury (Month, Day Year)	28b. Time Injury		ry at rk?	28d. Describe	how injury o	occurred	T		
SIOI tandir leath. tor: Al	atic	27. Mann of Death  28a. Date of Injury  (Month, Day Year)  28b. Time of Death  28d. Describe how injury occurred  28d. Describe how injury occurred										
INSION I or Attending after death. Director: Afte	rtff									ral Route Number,		
DIVISION To the Hospital or Attanding within 24 hours after death. To the Funeral Director: After completely filled in by the fune	edical C		hysician: To the best of my kn miner: On the basis of examin									
thin 2 the control	Med	one) 29b. Signature and title of certifier	and manner stated.		29c. Licen	se number		29d. Date s	signed (Month	, Day, Year)		
¥ ¥ ¥ 8		MM MD	completed cause of death (Ite		Do	7227		12/	80 /6			
		30. Name and address of person who	completed cause of death (Ite	m 23a) (Type	Walke	m Wa	ods la	m	. M	02.1234		
	State	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	La Company	7// / / / /	· w v	1000				
Regi		JAN 1 3 2009	Bosse p.	1900								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 43213 State of Maryland / Department of Health and Mental Hygiene 2 [] [] 8 Certificate of Death 2. Date of Death Month 3. Time of Death **Physician** WATKINS Anthony P M 620 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Palt mon ocedalt tranklin If Under 1 Year Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months Days Hours 215-46-7926 1**X**M 2□ F 61 MARY Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a. State 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Evantiner must be motified at BALTIMORE 1 Yes 2 □ No MD Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ECHODALE AVENUE U.S. A 21214 12. Was Decedent Ever in U.S. Armed Forces?

1 X/es 2 No If Yes, Give Year or Dates: 1966 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No BLACK Completed by Specify: 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Bethlehem STEEL Elementary/Secondary (0-12) College (1-4or 5+) STEEL WORKER 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) LAUCINA PERNAL SAMUEL WATKINS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health a Important: If item 27 Is any Injury or other trau once. 3604 Echodale Ave. BALTO, MD. 21214 WATKINS 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 01-09-2009 BALTIMORE, MD 1 Burial 2 □ Cremation 3 □ Removal from State KING MEMORIAL 4 Donation 5 DOther (Specify) 22. Name and Address of Facility VAUGHN GREENE FUNERAL SCUS 21. Signature of Funeral Service Licensee 4905 YORK ROAD, BALTIMORE, MD. 21212 -mo1555 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** metastate adenocarcinomo /Medical Due to (or as a consequence of): Examiner hay failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed RESPIYATOVY tall tailure attending physician and for use as the burial-tran Division of Vital Records, P.O. Box 68760, Physician/Medical Shock IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 MNo Month Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Thromboembolic 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b lirector, page 2 sl autopsy performe 1 □Yes 2 No 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 X Natural 5 Pending investigation within 24 hours ane, ....
To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signatu 55107 08 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1000 Franklin Guare Drive Baltimore MP 21237

Registrar

Dr. William Krimsky 31. Date filed (Month, Day, Year)

JAN 1 3 2009

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Day Month **Physician** 30, 2008 5:08 PM December William Walsh /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Cecil Union Hospital E1kton Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
July 15, 1 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 X M 2 □ F Months Days Hours 62 1946 Connecticut **Director** 156-38-5331 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Evantines must be notified at MD Kent Galena 1 ☐ Yes 2 ▼ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Indian Acres Lot 37 P.O. Box 71 21635 USA Funeral unk 12. Was Decedent Ever In U.S. Armed Forces?

larried | 1 Zives 2 | No | If Yes, Give | Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2K No Specify Specify: White Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry unk (Give kind of work done during most of working life. DO NOT use retired) unk College (1-4or 5+) Elementary/Secondary (0-12) unk unk unk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unk Be 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Holly Kohler/friend Box 142 Galena, MD 21635 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5 🖾Other (Specify) in state 21. Signature of pineral Service Livensee Ronald S. Wade Director 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Se uentiall, list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-tran that initiated events and resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) hed by the a detached for 1 Tyes 2 TNo 9 Unknown 9 Unknown s been signed be should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown Yes 24a, Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 No certificate has page 2 s 1 ☐ Yes 25. Was case referred to medical examiner? director, 26. Place of Death (Check onl one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 No Impatient 2 ER/Outpatient 3 DOA Certification: To After this funeral Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Mapner of Chath 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No r death. investigation within 24 hours after death

To the Funeral Director:
completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2. To the F 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Decreyber 30 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Street Elkton WO 21821 106 Bow Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-09432 State of Maryland / Department of Health and Mental Hygiene Peter Ronald Wilkins Certificate of Death 1- For State 2. Date of Death Registrar . Decedent's Name (First, Middle,Last) Month Day December 15, 2008 1422 hrs Physician/ **Medical Examiner** Peter Ronald Wilkins c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Harford Edgewood 1606 Ashby Square, Apartment I 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign If Under 24Hrs. If Under 1 Year 7. Age (In yrs. last birthday) Country) 5. Social Security Number 10 6. Sex Min **Funeral** Hours Days Months 1945 Pennsylvania Jan 11 63 Director 1 X M 2 Usual Residence of Deceden 10d. Inside City Limits 10c. City, Town or Location Oh County 1 Yes 2 X No Edgewood Harford MD or 28a-f show notified at once. 10g. Citizen of What Country? within 72 hours after death with the Maryland Director 10f. Zip Code 10e. Street and Number USA 21040 1606 Ashby Square #1 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-12. Was Decedent Ever in U.S. Funeral Armed Forces? 11 Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Married Yes Specify: white Baltimore, MD 21215-0036
permit. Pages I and 2 should be filled within 72 hours after de Department of Health and Mental Hygiene.
Important: filten 27 is marked other than "natural", or injury or other traumatic event. the New Yor! Yes 2 X No specify: If Yes, Give Yeer 4 X Divorced Widowed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done ģ 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) automotive salesperson unk unk 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Zillenah Wroten Russell Wilkins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1220 Dicus Mill Road Millersville, MD Charles Wroten/uncle 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Cremation 3 Removal from State Burial 2 Donation 5 X Other Specify: in state 22. Name and Address of Facility State Anatomy Board Baltimore, MD 2120 21. Signature of Funeral Servi S. Wade 655 W. Baltimore Street 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and **Physician** failure. List only one cause on each line Death a Atherosclerotic cardiovascular disease /Medical Immediate Cause (Final disease aminer Due to (or as a consequence of) or condition resulting in death) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last 23a,27,perm,E g887 1/16/09 Records, P.O. Box 68760, The law requires that the death certificate be executed pue Physician/Medical AMENDED X UNPENDED attending physician a or use as the burial -23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: Day Year Month 3 Ectopic pregnancy 23b. Was decedent pregnant in the Fetal death Live birth past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown q Linknown 23e. Did tobacco use contribute to the cause of death? icate has been signed by the a page 2 should be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 1 Yes 2 No 3 Probably 4 V Unknown ò 24b. Were autopsy findings available 24a. Was an Completed prior to completion of cause of autopsy certificate has been death? performed? 1 V Yes 2 No ✓ Yes 2 26.Place of Death (Check only one) 25. Was case referred to medical Hospital or Attending Physician: Other<sub>4</sub> Division of Vital Be Residence 6 V Other: Scene Hospital: 1 Nursing Home 5 DOA examiner? ER/Outpatient 3 Inpatient 2 this 1 V Yes 10 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) After Manner of Death Certification: 1 Yes 2 No 1 X Natural within 24 hours after death.

To the Funeral Director: A completely filled in by the fu Pending 28f. Location (Street and Number or Rural Route Number, City Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 2 Accident Could not be 3 Suicide 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 • Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier December 16, 2008

WF

30. Name and address of person who completed cause of death (Item 23a)

31. Date filed (Month, Day, Year)

2

Assistant Medical Examiner

DHMH 17 Rev 1/2001

State

Registrar

OCME

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

**ÖRIGINAL** 

			1 - State Registra AMEND#1p=rMD1	State of Ma 6/09,BMJ,McCo	-		ificate of		лептат пу	Reg. No.	2008	43216	
	Physicia	an	1. Decedent's Name (First, Middle, Last) Malzie Adassa Ashley							ath Day	Year	3. Time of Death	
	/Medic	al	4a. Facility Name (If not institution, giv				Ih City Town or	r Location of Death	December		2008 County of Deatl	12:30 aM	
	Examin	er	Adventist Health Care Sligo Creek Takoma Park							10.	Montgome		
	Funeral		5. Social Security Number 6. S		(In yrs. last b		If Under 1 Year					hplace (State or Foreign untry)	
	Director		5. Social Security Number  6. Sex 1 M 2 F 7. Age (In yrs. last birthday) 1 M 1 M 2 F 82  1 M 2 F 82  1 M 2 M F 82  1 M 3 M 1 M 1 M 1 M 1 M 1 M 1 M 1 M 1 M									Jamaica	
4	yeand Now		10a. State 10b. County 10c. City, Town or Location									10d. Inside City Limits	
3	a-f st	Director	Maryland Montgor	nery			Tai	koma Park	1 □Yes 2 🖾 No			1 □Yes 2 No	
į	or 28	Jire	10e. Street and Number				10f. Zip Code		10g. Citizen of What Country?			untry?	
4	23a		7520 Maple Avenue	e, Apt. 105				20912			U.S	S.A.	
36	z snoudo be lileo within 7.2 hours alter death with the maryand and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Macical Examinations to notificat	by Funeral	11. Marital Status  1 Never Married 2 Married	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give			s Decedent of H es, specify C <i>u</i> ba ]Yes 2⊠No	lispanic Origin? (Spean, Mexican, Puerto Specity:	ecify Yes or No Rican, etc.)		14. Race - Ame Black, White Specify:	e, etc.	
0	tural'	g pa	3 ☐ Widowed 4 ☒ Divorced  15. Decedent's E	Year or Dates:	16	a Deceder	nt's Usual Occup	ation			nd of Business/l	Black	
15	in 'z	Completed	(Specify only highest gra	ade completed)		(Give kir		durina most of worki	ing		is of Basilloss.	, industry	
212	giene grene er tha	ĕ	Elementary/Secondary (0-12)	College (1-4or 5+ 4	,	R	egistered	Nurse	Healthcare Serv			Services	
פ	al Hy othe vent,	Be C	17. Father's Name (First, Middle, Last	)				18. Mother's Name	(First, Middle	, Maiden	Surname)		
<u>a</u>	snould be and Mental s marked o umatic eve	일							Adalaine	Allis	on		
lar	and and is ma		19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and N				and Number or Rura	al Route Numb	er, City o	r Town, State, Z	Zip Code)		
≥ ;	and sealth m 27 her tr		Audrey E. Francis	- Niece				ue, Adelphi	<del> </del>				
Baltimore, Maryland 21215-0036	ges i it of H if ite or otl		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place cemet	of Dispositi tery, crema	ion (Name of tory or other plac	ce)	Date	20c. Lo	cation - City or	Town, State	
֓֞֞֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֟֓֓֓֓֓֓֓֓֓֓֓֓֟֝֟֓֓֓֓֓֓	tmen rtant:		4 ☐ Donation 5 ☐ Other (Special		George	_		etery 01/04	/2009	Ade	elphi, Ma	ryland	
Ba	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce.		21. Signature of Funeral Service Live	nsee	tu	Hin	Name and Addre es-Rinald 00 New Ha	i Funeral H	ome, Inc.	ver Sp	oring, Man	ryland 20904	
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that caused t	he death. Do	o not enter	the mode of dyir	ng, such as cardiac	or respiratory a	rrest,		Approximate Interval Between	
P	hysician		Immediate Count Final disease or condition Hypoxia									Onset and Death 2-3 months	
	/Medical		resulting in death)	Due to (or as a		e of):							
	xaminer	L	Sequentially list conditions, If any, leading to immediate  b. Arythmia Due to (or as a consequence of):										
Ţ	red Isit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury	c. Electrol		_ ′							
	and and	Examiner	that initiated events resulting in death) Last										
68760, ##@## ## @@@###	physician and the burial-transit												
687	ng phy as the	edical		0									
O. Box		Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome o 1  Live birth 2 4  Pregnant at 9  Unknown	Fetal dea		Ectopic pregnanc Other <i>(sp</i> ec <i>ify)</i> _	у		2	23d. Date of deli Month	ivery Day Year	
<b>d</b> .	ned by deta		Part II. Other significant conditions	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death?			
Records,	n sign	Ď.	Metastatic Liver	Cancer					1 🗆	Yes 2	□ No 3□ Pr	obably 4₺ Unknown	
ဝ လ	s been s	Completed by							24a. Was		24b. Were au	topsy findings available	
ř	siciari. The law certificate has irector, page 2 t	E							auto perfo 1 □Yes	rmed?	death?	completion of cause of 2  No	
		Be C	25. Was case referred to medical					26. Place of Death			I ILITES	2 🗀 110	
	this certific al director, I	To E	examiner? 1 ∐ Yes 2 ဩ No	Hospital: 1 ☐ Inpatien	it 2 ☐ ER/0	Outpatient	3 ☐ DOA Oth	er: 4 🖾 Nursing Ho	me 5 ☐ Resi	dence 6	G ☐ Other (Spec	cify)	
Division of Vita	ath. r: After the funeral	ation:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigatio	28a. Date of Injury (Month, Day, n	Year) 28b	. Time of Injury	28c. Injur Worl M 1 🗆	yat k? Yes 2 ∐ No	28d. Describe	how injury	y occurred		
- 1	- 9	Certification:	3 □ Suicide 6 □ Could not be determined		y - At home, (Specify)	farm, stree	t, factory, office		28f. Location (Street and Number or Rural Route Number, City or Town, State)			ıral Route Number,	
200	or the hospital or Attendation within 24 hours after death.  To the Funeral Director: After completely filled in by the fun	Medical C		hysician: To the best of miner: On the basis of and manner stat	examination a								
Ę	Withi Comp	M	29b. Signature and tile of certifier  29c. License number  D56147							29d. Dat	e signed (Month	n, Day, Year)	
	V									December 29, 2008			
			30. Name and address of person who										
			Nasreen Mustafa 1 31. Date filed (Month, Day, Year)	Kango, M.D.,	de Signaturo	- 4		koma Park, l	Maryland	20912			
	Sta Registr		PR 100 CO		, K	die	LE D						
					-	87							

**Funeral** Director

		State of Maryland	-	rtment of H		Mental Hy	giene Reg. No.	2000	12217			
Physicia	an	1. Decedent's Name (First, Middle, Last)  Josephine Marie Braswell		- Inouto or E		2. Date of De Month	ath		3. Time of Death 3:50 A M			
/Medic Examin		4a. Facility Name (If not institution, give street and number) 3641 S. Leisure World Blvd., #1	С	4b. City, Town, or Silver S			4c. (	County of Death				
uneral Director		5. Social Security Number 037-26-7643   6. Sex 1 □ M 2 ☒ F   7. Age (In yrs. Ia grant   1 □ M 2 ☒ F   6. Sex 1 □ M 2 ☒ F   7. Age (In yrs. Ia grant   1 □ M 2 ☒	ast birthday) 1 Yrs.	If Under 1 Year Months Days	if Under 24 Hrs Hours Min.	8. Date of Bi (Month, D. June 9	v. Year)	Cou	place (State or Foreign intry) le Island			
a-f show ilind at	ctor	10a. State 10b. County 10c. City	Town or Loc Lver Sp						10d. Inside City Limits 1 ☐ Yes 2 No			
s 23a or 28 ust be not	ral Director	3641 S. Leisure World Blvd., #10		10f. Zip Code 20906			Unit	zen of What Cou ted Stat				
ral", or items Examinar n	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S Armed Forces?  1 □ Yes 2 ☑ No If Yes, Give Year or Dates:		Vas Decedent of His Yes, specify Cubar □Yes 2⊠No	spanic Origin? (S n, Mexican, Puerl Specify:	Specify Yes or No to Rican, etc.)		14. Race - Ameri Black, White, Specify: W				
Department or heaft and wenter hygens.  Department or heaft and when the heaft show any injury or other traumatic event, the Medical Everging must be notified at once.	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)  12	(Give k life. D	ent's Usual Occupa kind of work done d O NOT use retired)	uring most of wor	rking		od of Business/Ir	ndustry			
wentar rygrarked other	To Be Co	17. Father's Name (First, Middle, Last) George Nasser	rayro		18. Mother's Nar		Maiden S					
m 27 Is mo		19a. informant's Name/Relationship (Type. Print)  Barbara J. Braswell (Daughter)	3641	S. Leisu		l Blvd.,	#1C,	, Silver	Code) 20906 Spring,MD			
rtment of r rtant: if ite		1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State M.	metery, crem letropo Crema	atory	27,	Date ember 2008	Alexa	cation - City or To	Virginia			
Impo any i		21. Signature of Funeral Service Licensee  23a. Part 1. Enter the disease, or complications that caused the death.	D		Drive,	Gaithers	burg		and 20877			
/sician ledical		shock, di heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Congestive  Due to (or as a consequence)	Heart		g, such as cardia	c or respiratory a	rrest,		Approximate Interval Between Onset and Death			
aminer	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury)  Aortic Sten  Due to (or as a consequence of the conseq	osis									
physician and s the burial-transit	dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence)	ence of):				-					
To the Funeral Director: After this certificate has been signed by the attending of completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director.	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 Mo 9 ☐ Unknown  23c. If yes, outcome of pregnant 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3 🗌	Ectopic pregnancy Other (specify)			23	3d. Date of deliv Month	ery Day Year			
en signed b	þ	Part II. Other significant conditions contributing to death but not resul	ting in the und	derlying cause give	n in Part I.				he cause of death?			
icate has be r, page 2 sh	Completed					24a. Was autop perfo 1 □ Yes	rmed?		opsy findings available impletion of cause of			
s certii irecto	Be	25. Was case referred to medical examiner?  1  Yes 2 XNo  Hospital: 1 Inpatient 2 E	D/Outpations	Othor	26. Place of Dea							
rr. After this	ation: To	27. Manner of Death  1 SNatural 5 Pending 2 Accident investigation  28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury Work?	at	28d. Describe I			(y)			
rai Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At hom building, etc. (Specify)				City or Tov	vn, State)		al Route Number,			
the Fune	Medical	29a. Certifier (Check only one)  1 ☐ Certifying Physician: To the best of my know 2 ☐ Medical Examiner: On the basis of examination and manner stated.	ledge, death on and/or inve	estigation, in my op	inion, death occu	irred at the time,	date and p	place, and due to	o the cause(s)			
2		29b. Signature and title of certifier	WD	29c. License				mber 22				
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Robert L. Gold, M.D., 15225 Shady Grove Road, #201, Rockville, Maryland 20850										
Stat Registra		31. Date filed (Month, Day, Year)  DEC 3 0 2008  32 Registrar's Signatu	lire Appar	w								

State of Maryland / Department of Health and Mental Hygiene 43218 Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Dec. 28, 2008 4:40a M Voshall Bohrer Marian /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Silver Spring Holy Cross Hospital If Under 1 Year | If Under 24 Hrs. (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 3/16/1918 . Social Security Numbe 9. Birthplace (State or Foreign **Funeral** Days 579-07-9867 1 □ M 2 🛛 F Months Hours Alabama Director Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylanment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the modical Exp. (in recounts to modified at 1 □Yes 2 No Director MD Montgomery Silver Spring 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 10416 Hemley Lane 20902 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 X No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: Specify: ≥ 3 ☐ Widowed 4 🕅 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Federal Gov't Administrative Assistant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Myrtle Brodbeck Roy D. Voshall 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health an Important: If item 27 is any injury or other trau once. 136 Hesketh Street Chevy Chase, Md 20815 Richard C.Bohrer/Son 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Chesapeake Crem. 12/30/2008 Beltsville, Md 5 ☐ Other (Specify) 4 ☐ Donation 21. Signature Funeral Service Li PHTETPANDSRTWALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Severe aortic stenosis disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Congestive heart failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Examine certificate be executed Failure to thrive attending physician and for use as the burial-tran Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant law requires that the death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) ☐Yes 2 XNo P.O. | signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No has autopsy certificate 1 □Yes 2**X** No Hospital or Attending Physician: 7 24 hours after death. Funeral Director; After this certifica stely filled in by the funeral director, p. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral D 29a. Certifier 1 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 🗆 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Dec.29,2008 D60826 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Kshama Garg MD Glen Drive Silver Spring, Md20910 31. Date filed (Month, Day, Year) 32 Registrar's Signature State DEC 3 0 2008

DHMH 17 Rev 1/2001

Registrar

			1 - For State Registrar		Maryland /		rtment <i>tificate</i>			and M	, ,	giene leg. No.2 (	800	432	19
	Physici	an	1. Decedent's Name (First, Middle,		D !:						Date of Dea     Month	Day	Year	3. Time of De	eath
	/Medic	al	Ethel T.		Barile		41. 01. 7.		1 2		Decemb	er 28,		9:15	ам
	Examin	er	4a. Facility Name (If not institution, 10 Hickory Aven	•	er)		4b. City, To		Location o Park				nty of Death		
	Funeral				Age (In yrs. last i	birthday)	If Under 1	Year	If Under 2	24 Hrs.	8. Date of Birth	)	on tgom		oreian
	Director		578-32-4208	1 □ M 2 K F	98	Yrs.	Months I	Days	Hours	Min.	April 1	, Year)		lace (State or F stry) ryland	oreign
	pu.		Usual Residence of Decedent  10a. State 10b. County		10- 07- 7-		-41								
	laryla sho	5			10c. City, To								1	0d. Inside City I 1 ☐ Yes 2	
	the N	Directo	Maryland Montg	omery	T	akoma	Park					0g. Citizen o	£ 18/h at Cause		
	3a or		10 Hickory Ave	nue				091:	2			US		ury r	
	death	Funeral	11. Marital Status	12. Was Deceder	nt Ever in U.S.	13. V				gin? (Spe	ecify Yes or No- Rican, etc.)		ace - Americ	an Indian,	
9	thin 72 hours after death with the Maryland e. "natural", or items 23a or 28a-f show Mulical Evanther nut be motiff, deat		1 Never Married 2 Married	Armed Force 1 ☐ Yes 2x If Yes, Give			Yes, specify □Yes 2√E		Specify:	, Puerto	Rican, etc.)	1	lack, White, e		
9200-91212	ural",	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Date:								Spec	White	9	
-c	"nat	Completed	15. Decedent's (Specify only highest	Education grade completed)	16	Sa. Deced (Give	ent's Usual ( kind of work of OO NOT use	Occupa do <i>ne du</i>	tion <i>ıring most</i>	of workii	ng	16b. Kind of	Business/Ind	lustry	
7.	filed within 72 Hygiene. other than "na ent, the Mulic	duc	Elementary/Secondary (0-12)	College (1-4o	r 5+)		emaker	reurea)				0	**		
-	be filed wit ital Hygien id other tha event, the	Be C	17. Father's Name (First, Middle, La			Home	maker		18. Mother	r's Name	(First, Middle, I		Home ame)		
Maryland	Aenta Aenta rked ric ev	To B	Emil Meyers					L.,	heres				•		
ary	and N	Γ,	19a. Informant's Name/Relationship	(Type. Print)	19	9b. Mailin	g Address (S	Street al	nd Numbe	r or Rura	l Route Number	; City or Tow	n, State, Zip	Code)	
_	ss 1 and 2 should be fi of Health and Mental H i item 27 is marked ot r other traumatic ever		Patricia A. Jea	an Barile/	Daughter :	10 ні	ckorv	Ave	enue.	Tak	oma Par	k. Mar	vland	20912	
saltimore,	Jes 1		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3		20b. Place	of Dispos tery, crem	sition (Name atory or other	of er place,	)	D	ate	20c. Location	- City or To	wn, State	
Ē	Pag tmeni tant: jury o		4 □ Donation 5 □ Other (Spe		Gate		Ieaven			У	an. 2, 2009	Silve	r Spri	ing, Mars	71an
a a	permit. Pages Department of I Important: If ite any Injury or or once.		21. Signature of Funeral Service Lic	ensee		F 1	Name and A	Address J.	of Facility	ins	Funeral	Home	Inc.		
	202 % G		Joken J	Jan			0 Uni	vers	itv	Blvd	. W S	ilver	Spring	, MD 20	1901
		97 N	23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final	ly one cause on each	line.	o not ente	er the mode o	ot ayıng	, such as o	cardiac o	r respiratory arre	est,		Approximate Interval Betwee Onset and Dea	∍n ith
	Physician /Medical		disease or condition resulting in death)	a Aspirat			a							week	
· I	Examiner			especialistate and the	as a consequence	na resource		-020	2020000						
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Severe Due to (Jr a	Generali Is a consequenci		Muscl	No.	akne	SS			1	year	
6	cuted nd ransit	Examiner	Cause (Disease or injury that initiated events	C.											
,00	e exe ian aı ırial-t		resulting in death) Last		is a consequence	e of):								<del> </del>	
9	icate be executed physician and the burial-transit	dical		d											
Ď į	ding p	Med	IF FEMALE:	000 14			-								
200	Attending Frystcian: The law requires that the death certhing or death.  ector: After this certificate has been signed by the attending the funeral director, page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?		2 Fetal dea		Ectopic preg						ate of deliver	ry Day Yea	r
ָ כ	y the ched	ysic	1 □ Yes 2 ဩZNo 9 □ Unknown	9 ☐ Unknowr	at time of death	5 🗆	Other (speci	'ty)							
, T	that ned b		Part II. Other significant conditions	contributing to death	but not resulting	in the un-	derlying caus	se given	in Part I.		23e. Did tob	acco use co	ntribute to the	e cause of deat	h?
cords,	quires in sign	d by	Decubitus Ulcer	s							1 □ Ye	s 2 <b>K</b> No	3 ☐ Proba	ably 4 🗆 Unki	nown
ວ	s bee	olete									24a. Was ar	24b	Were auton	sy findings avai	ilable
֓֞֞֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֡֓֓֡֓֓֓֓֡֓֓֡	ine ha	Completed									autops; perform	ned?	prior to com death?	pletion of cause	e of
<u> </u>	lan: rtifica stor, p	BeC	25. Was case referred to medical	1				- 2	26. Place	of Death	1 □Yes 2 (Check only one		1 □ Yes	2 □ No	
>	nysic nis ce I direc		examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpa	tient 2 ER/C	Dutpatient	3 □ DOA	Other			ne 5 <b>k</b> Reside	· · · · · · · · · · · · · · · · · · ·	ther (Specify	)	
5	ng P	ü	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of In (Month, D	jury 28b. Day, Year)	Time of Injury	28c.	Injury a			8d. Describe ho				
2	renal eath. or: A the fu	cati	2 Accident investigati 3 Suicide 6 Could not	bo i			М	1 □ Ye	s 2 🗆 N	lo					
2	or Attencafter death	Certification: To	4 Homicide determine	d   28e. Place of II	njury - At home, f etc. <i>(Sp</i> ec <i>ify)</i>	farm, stre	et, factory, of	fice		2	8f. Location (Str City or Town	eet and Num , State)	ber or Rural	Route Number,	
ב ו	purs a ours a eral [		29a. Certifier 1 Certifying I	Shusialan, Takka kas	A of m l			N - 4		- 10					
1	to the roportial or standing priystician: The law requires that the death certificate be executed within 24 hours after death.  *To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	(Check only one)	Physician: To the bes aminer: On the basis and manners	of examination a	ge, death and/or inv	estigation, in	my opi	e, date and nion, death	d place, a h occurre	and due to the ca d at the time, da	ause(s) and rate and place	nanner as sta , and due to t	ated. the cause(s)	
1	within Fo the complete complet	Me	29b. Signature and title of certifier				29c. Li	icense r	number		29	d. Date sign	ed (Month, D	ay, Year)	
<b>)</b>	15		1 lobert	Jamas	MD		/	ni	) 20	026		DEC.			
	11		30. Name and address of person wh												
			Robert Ramsey,		Georgi			NW,	Wash	ingt	on, DC	20307			
	Stat Registra	~	31. Date filed (Month, Day, Year)  DEC 3 0 2	nng samegis	trar's Signature	A STATE OF	A STATE OF THE PARTY OF THE PAR								
			DEO 3 U Z	UUU LUUU		1									

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year Kathleen Clarke Bonifas 1 200 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death St. Mary's Hospital St. Mary's Leonardtown 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Months Days Hours Min. 368-26-5121 80 08/29/1928 Michigan Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland St. Mary's Lexington Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21895 Pegg Road 20653 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 ∐Yes 2 XI If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No Specify. Specify: 3 XWidowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Printer State Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hilda Victoria Denham Robert Edward Clarke 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra K. Butler/Daughter 23160 Gunston Drive, Lexington Park, MD 20653 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Episcopal Cem 01/07/2009 | St. Mary's City, MD 4 ☐ Donation 5 ☐ Other (Specify) Trinity 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Road, Leonardtown, MD 20650 Signature of Funeral Service Livesee 22. Name and Address of Facility Brinsfield Funeral Hornward N. Brinsfield, Jr. M00052 22955 Hollywood Road, Leonardtown, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final neumonia 4 days disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ ¶o 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 □Yes 2 No 2 □ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

show

28a-f

ò 23a

or items

"natural"

permit. Pages 1 and 2 should be filed within 72. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natuany injury or other traumatic even."

death with the

72 hours after

altimore, Maryland 21215-0036

Director

Funeral

2

Completed

Be

ည

traumatic event, the Medical Examination rust be notified at

Exami burial-tran Physician/Medical the use as t for

and attending physician the detached signed by t I be detach page 2 should funeral director, After this

2

Completed

Be

Certification: To

Medical

completely

27. Manner of Death

1 Natural
2 Accident

3 Suicide

29a. Certifier

4 - Homicide

(Check only one)

death. within 24 hours after death To the Funeral Director: filled in by the

requires that the death certificate be execu Box 68760. P.O. Division of Vital Records, Attending ö

Hospital

de State Registrar

29b. Signature and title of certifier

28a. Date of Injury (Month, Day, Year) 5 Pending investigation 6 ☐ Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

1 ☐ Yes 2 ☐ No

1 Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

125230

28c. Injury at Work?

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29d. Date signed (Month, Day, Year) 1-1-2209

28f. Location (Street and Number or Rural Route Number, City or Town, State)

20650

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

25500 Point Lookout Road, Leonardtown, MD David Allen, M.D.

31. Date filed (Month, Day, 5 2009 . Registrar's Sign

Mi

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State | 12/30/2008 | 1- Registrar | 1 tem #20b, 20c, per/F. Home Certificate of Death DH, WCHD Reg. No. 43221 Amended 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Dec. 27. 2008 10:20 <u>I</u>da Ruby Balladarsch /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4 Dune Grass drive Berlin Worcester 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Yrs Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2/CXF Director 89 214-24-7220 July 5, 1919 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ital Wadish Evandust must be notified at 10d, Inside Cify Limits Director 1 ☐ Yes ≯(X)No MD Worcester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 4 Dune Grass drive 21811 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 1 Yes 3 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 □Yes XXNo Specify: white ð Specify: White 3 → Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9th homemaker home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Albert Maykrantz Ethel Eline ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4 Dune Grass drive Berlin, MD 21811 Gaylee Mays - daughter 20a. Method of Disposition Baltimore, 20b. Place of Disposition (Name of cemeters crematory or other place)

Cape Henlopen Crem. 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 12/30/2008 Frankford Delaware 4 ☐ Donation 5 ☐ Other (Specify) Henelope Crem. Cape Dec. 30. 22. Name and Address of Facility Burbage funeral home 21. Signature of Funeral Service 108 Williams street Berlin, MD 21811 23a. Part 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final STENOSIS **Physician** OPTIC disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): attending physician for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4 ☐ Pregnant at time of death 5 Other (specify) 9 ☐ Unknown 9 Unknow Ś Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? icate has been si 7, page 2 should b 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe this certificate 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After thi 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation n 24 hours after death.

e Funeral Director: Aft
bletely filled in by the fur 1 ☐ Yes 2 ☐ No 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal 29a. Certifier (Check only one) Medi within 2 To the F 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Glenn K. Arzadom 9714 Healthwa

State DHMH 17 Rev 1/2001

DN 2

31. Date filed (Month, Day, Year) DEC 3 0 2008 Registrar

32. Registrar's Signature

	State of Maryland / Department of Health and Mental Hygiene  1- State Amended item#10b, WCHD, SLU, 12/20/1980 (Amended item#10b, WCHD, SLU, 12/20/1980)  1- State Amended item#10b, WCHD, SLU, 12/20/1980 (Amended item#10b, WCHD, SLU, 12/20/1980)  1- State Amended item#10b, WCHD, SLU, 12/20/1980 (Amended item#10b, WCHD)											
		۰	1. Decedent's Name (First, Middle, Last)	2. Date of Deat		3. Time of Death						
	Physici /Medi		translin W. Bratten	Menth Lkc:	28 2008	1605 M						
and a	Examir	ner	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  Peninsula Regional Medical Center  Salisburu		4c. County of Death Wicomi							
Ī	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	Year) 9. Birth	place (State or Foreign						
	Director		Usual Residence of Decedent	124	. 1950	Maryland						
	Marylar f show	Ď	10a. State 10b. County WOI CESTER 10c. City, Town or Location			10d. Inside City Limits  1 ☐ Yes 2 ☐ No						
	ith the lor 28a.	Director	10e. Street and Number 10f. Zip Code	1	0g. Citizen of What Cour	ntry?						
	eath w	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp	pecify Yes or No-	14. Race - Ameri	can Indian						
36	or iter		Armed Forces? If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White,							
00-	2 hours atural" cal Ex	ted by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:		16b. Kind of Business/In	dustry						
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natura", or items 23a or 28a-f show ont, the Modical Evertime Livest by motified at	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  (Give kind of work done during most of work life. DO NOT use retired)	king	Town of	2 0						
	al Hygie other t	Be Co	17. Father's Name (First, Middle, Last)  18. Mother's Name	e (First, Middle, N	(UWI) OF ( Naiden Surname)	Mean City						
Maryland	ould be d Mental narked o	ပ္	Roger Harmon Glad	245	Bratt	en						
	and 2 sh ealth and n 27 is n her traun		19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Ru	SDW4 /	City or Town, State, Zip	Code)						
Baltimore,	es 1 of H fiter rott		20a. Method of Disposition  20a. Method of Disposition (Name of Cemetery, crematory or other place)	Date	20c. Location - City or To							
Ħ H H	7 He a		4 Donation 5 Other (Specify)  21,965 Tu, if Funeral Service Lice 22. Name and Address of Facility	09 1	nurdle tre	e, Md.						
å	permit. Departm Importa any inju		Bennie Smith Functal	Herre gin	W.Ischellast. S	elishury 21801						
		27 1	23a. Part 1. Enter the dease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart fallure. List only one cause on each line.  Immediate Cause (Final	or respiratory arre	est,	Approxi te Interval Between Onset and Death						
and the second	Physician /Medical		disease or condition resulting in death)  a.   Wholers broken hemorrhage Due to (or as a consequence of):	•								
	Examiner	į.	Sequentially list conditions, if any, leading to immediate b.  Due to (or as a consequence of):									
	cuted nd ransit	Examiner	if any, leading to immediate cause. Enter Underlying Course Cheecker it jury that initiated events Due to (or as a consequence of):									
60,	cate be executed physician and the burial-transit		resulting in death) Last  Due to (or as a consequence of):									
687		<b>dedical</b>	d.									
Box	death certific e attending p d for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 □ Live birth 2 □ Fetal death 1 □ Live birth 2 □ Fetal death 1 □ Live birth 2 □ Fetal death		23d. Date of delive	ery Dav Year						
О	0 0	hysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown 9 ☐ Unknown									
	The law requires that the disternance has been signed by the page 2 should be detached	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Metasfufuc Cancer		acco use contribute to the							
Records,	w requ	ompleted		1 ☐ Ye	s 2 No 3 Prob	psy findings available						
		Comp		autopsy perform 1 □ Yes 2	/ prior to co	mpletion of cause of						
Vital	ysician; The is certificate director, pag	o Be	Hospital:	h (Check only one	9)							
Division of	Attending Physician: yr death. ector: After this certific by the funeral director, I		1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Holes Hospital: 1 Nother: 4 Nursing Holes Hospital: 1 Natural 5 Pending (Month, Day, Year) 28b. Time of Injury Work?	ome 5 ☐ Reside 28d. Describe ho	nce 6 Other (Specified winjury occurred	y)						
Sio	vttendii death. ctor: A y the fu	Certification:	2 Accident investigation 2 Accident investigation 3 Suicide 6 Could not be 280 Place of Injury. At home form effect of the uniform.	20f Looglier (Ot		18 1 1 1						
2	tal or A rs after al Direct ed in b	Certif	4 Homicide determined building, etc. (Specify)	City or Town,	eet and Number or Rura State)	i Houte Number,						
	To the Hospital or Attending Phys within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral di	Medical	29a. Certifier  (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, consider the construction of the basis of examination and/or investigation, in my opinion, death occur and manner stated.	and due to the carred at the time, da	ause(s) and manner as s	tated. the cause(s)						
	To the within To the comple	Med	29b. Signature and title of certifier 29c. License number	29	d. Date signed (Month,	*						
	~ ~~/		D29105		12-29.	08						
_	122an		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Chrus ion Huddles Ton MD. 100 e. CAnnull St. Salishur.  31. Date filled (Month Day, Year)  32. Reflictar's Signature	ns Md	21801							
	Sta Registr		31. Date fired (Month, Day, Year) DEC 3 0 2008  32. Registrar's Signature	1								
	- negioti		Francis or Losses									

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 08:05 AM 2008 Wayne Ray Blockston /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Peninsula Regional Medical Salisbury WICOMICO If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days Hours Min 1 X M 2 ☐ F Yrs 53 Director 214-66-7959 June 18, 1955 Maryland Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Evandon in the retiffind at once. 1X Yes 2 No Sussex Delmar Director Delaware 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 19940 U.S.A. 306 North Second Street 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 21X No If Yes, Give 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: <u>ک</u> white 3 ☐ Widowed 4 🖾 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Equipment Operator Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Milton Blockston Barbara Buckle ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Delmar, MD 21875 (Stepfather) 404 S. Memorial Drive Charles T. Moore 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Crematory of Delmarva 12-29-2008 Delmar, Delaware 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Short Funeral Home
13 E. Grove Street 21. Signature of Funeral Service Licensee Delmar, DE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Sensis **Physician** disease or condition resulting in death) /Medical Due to (or as a conseque ce of): diferse Examiner Sequentially list conditions, if any, leading to infine date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for selections are Examine Hospital or Attending Physiclan: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 🗆 Ectopic pregnancy in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed' certificate 1 ☐ Yes 1 ☐ Yes 2 HNO director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural after death. M 1 □ Yes 2 □ No 2 Accident 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in 24 hours a Funeral ( 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) ca completely (Check only one) and manner stated within 2 To the I 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) HO059368 08 30. Name ap address of person who completed cause of death (Item 23a) (Type, Print) John Visuli 100 E. Carvoll 32. Registrar's Signature 31. Date filed (Month, Day, Year) DEC 3 0 Registrar

Physiciar /Medica Examine

Funeral Director

	◀ _ State	State of Marylan		rtment of H		Mental Hyg	iene <sub>eg. No.</sub> 2008	3 43224				
	Registrar  1. Decedent's Name (First, Middle, Last)		0071	meate of E	- Call	2. Date of Deat		3. Time of Death				
an	Lois Evelyn Culpe	pper				Month Decemb	Day Year er 28, 200					
al er	4a. Facility Name (If not institution, give stre	eet and number)		4b. City, Town, or	Location of Dea		4c. County of De					
CI	Hillhaven Nursing C			Adelphi			Prince C	George's				
	Social Security Number	7. Age (In yrs. i	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min			irthplace (State or Foreign Country)				
	579-28-9398	28CF 90	Yrs.	IVIOTITIS Days	TIOUIO IVIII	June 28		Laska				
	Usual Residence of Decedent  10a. State 10b. County	10c Cit	y, Town or Loca	ocation 10d. Insi								
ō	Maryland Montgome							1 □Yes 2 🛣 No				
rect	10e. Street and Number	Ly	priver	Spring 10f. Zip Code		1	10g. Citizen of What Country?					
٥	9808 Dilston Road			20904			USA					
Be Completed by Funeral Director		Was Decedent Ever in U.	S. 13. Wa		spanic Origin? (	Specify Yes or No- to Rican, etc.)	14. Race - Am	nerican Indian,				
Fur	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐Yes 2 ☐XNo				to Rican, etc.)	Black, Whi	ite, etc.				
by	¾√√Widowed 4 □ Divorced	If Yes, Give Year or Dates:	111	⊒Yes 2. TNo	Specify:		Specify:	White				
etec	15. Decedent's Educati (Specify only highest grade co	on ompleted)		nt's Usual Occupa ind of work done d		rkina	16b. Kind of Business	s/Industry				
du	Elementary/Secondary (0-12)	College (1-4or 5+)	`life. DC	O NOT use retired,	)							
Ŝ	12		Hor	memaker	40 Mathada Na	ma (Finat Middle A	Own Ho	me				
Be	17. Father's Name (First, Middle, Last)					me (First, Middle, M	Maiden Surname)					
မ	Clyde E. Bell  19a. Informant's Name/Relationship (Type.	Drint)	10h Mailine	Addross (Street s		Tucker	, City or Town, State,	Zin Code)				
	Glenn E. Culpepper/		_				Silver Spr	, ,				
	20a. Method of Disposition			tion (Name of tory or other place			20c. Location - City o					
	1  Burial 2 ☐ Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)	ioval from State			e) ; D∈	2008 I						
	4 Donation 5 Other (Specify)  Parklawn Memorial Park 2008 Rockville, Maryland  21. Signature of Funeral Service Licensee  Parklawn Memorial Park 2008 Rockville, Maryland  22. Name and Address of Facility. Francis J. Collins Funeral Home Inc.											
	1 Kelst ()/ to							ng.MD 20901				
	23a. Part 1. Enter the disease, or complicat	ions that caused the death						Approximate Interval Between				
	shock, or heart failure. List only one of immediate Cause (Final disease or condition							Onset and Death  Vears				
	disease or condition resulting in death)  a. Dementia  Due to (or as a consequence of):											
	Sequentially list conditions, b.											
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequ	uence of):									
каш	that initiated events c resulting in death) Last	Due to (or as a consequ	vonce of									
		Due to (or as a consequ	derice oi).									
dical	d											
/Me	IF FEMALE: 23b. Was decedent pregnant 23c.	if yes, outcome of pregna	ancy				23d. Date of de					
ciar	in the past 12 months?			Ectopic pregnancy	,		Lou. Date of a	alivery				
		in the past 12 months?    Columbia   Columbi										
hys	9 ☐ Unknown	4 ☐ Pregnant at time of d 9 ☐ Unknown	leatii 5 🗆 C				Month					
y Phys	9 ☐ Unknown  Part II. Other significant conditions contrib	9 Unknown		Other (specify)		23e. Did tob						
ed by Phys	4/1	9 Unknown		Other (specify)			pacco use contribute	Day Year				
pleted by Phys	4/1	9 Unknown		Other (specify)		1 ☐ Ye	pacco use contribute us 2 X No 3 ∏ F	Day Year  to the cause of death?  Probably 4 Unknown				
Completed by Phys	4/1	9 Unknown		Other (specify)		1 ☐ Ye 24a. Was ar autops perforn	pacco use contribute  is 2  No 3  Final Pack  24b. Were a prior to death?	Day Year  to the cause of death?  Probably 4 Unknown  autopsy findings available ocompletion of cause of				
Be Completed by Physician/Med	Part II. Other significant conditions contrib	9 □ Unknown  Duting to death but not resu		Other (specify)	en in Part I.	1 ☐ Ye  24a. Was ar autops perforn	pacco use contribute  s 2 🔀 No 3 ☐ F  24b. Were a prior to death? \$₹ No 1 ☐ Ye	Day Year  to the cause of death?  Probably 4 □ Unknown  autopsy findings available completion of cause of				
Be	Part II. Other significant conditions contrib	9 □ Unknown  Duting to death but not result in the second	ulting in the und	Other (specify)erlying cause give	en in Part I.  26. Place of De	1  Ye  24a. Was an autops perforn 1  Yes 2  ath (Check only one)	pacco use contribute us 2 ⊠ No 3 ☐ F us 2 № Were a prior to death? 1 ☐ Ye s) nnce 6 ☐ Other (Sp	Day Year  to the cause of death?  Probably 4 Unknown  autopsy findings available ocompletion of cause of				
Be	Part II. Other significant conditions contrib	9 ☐ Unknown  Duting to death but not resu	ulting in the und	Other (specify)  erlying cause give  3 □ DOA Othe  28c. Injury Work	26. Place of De	1  Ye  24a. Was an autops perform 1  Yes 2 ath (Check only one	pacco use contribute us 2 ⊠ No 3 ☐ F us 2 № Were a prior to death? 1 ☐ Ye s) nnce 6 ☐ Other (Sp	Day Year  to the cause of death?  Probably 4 Unknown  autopsy findings available o completion of cause of				
Be	Part II. Other significant conditions contrib	9 ☐ Unknown  puting to death but not result of the put not result	ER/Outpatient 28b. Time of	Other (specify) erlying cause give  3 □ DOA Othe 28c. Injury Work 1 □ \	26. Place of De	1  Ye  24a. Was an autops perforn 1  Yes 2 ath (Check only one-	acco use contribute  as 2 🔀 No 3 🗆 F  24b. Were a prior to death? 250 No 1 🗆 Ye  b)  ance 6 🗆 Other (Sp. w injury occurred	Day Year  to the cause of death?  Probably 4 □ Unknown  autopsy findings available completion of cause of s 2 □ No				
Be	Part II. Other significant conditions contrib	9 ☐ Unknown  puting to death but not resu	ER/Outpatient 28b. Time of Injury	Other (specify) erlying cause give  3 □ DOA Othe 28c. Injury Work 1 □ \	26. Place of De	1  Ye  24a. Was an autops perforn 1  Yes 2 ath (Check only one-	pacco use contribute  as 2 ⊠ No 3 ☐ F  by  contribute  24b. Were a prior to death? 1 ☐ Ye e)  contribute  1 ☐ Ye e)  contribute  24b. Were a prior to death? 1 ☐ Ye e)  contribute  24b. Were a prior to death? 1 ☐ Ye e)  contribute  24b. Were a prior to death? 1 ☐ Ye e)  contribute  24b. Were a prior to death? 1 ☐ Ye e)	Day Year  to the cause of death?  Probably 4 □ Unknown  autopsy findings available completion of cause of s 2 □ No				
Be	Part II. Other significant conditions contrib	pital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day, Year)  28e. Place of Injury - At ho building, etc. (Specification)	ER/Outpatient 28b. Time of Injury ome, farm, stree y)	Other (specify) erlying cause give  3 □ DOA Other 28c. Injury Work 1 □ N t, factory, office	26. Place of De  26. Place of De  27. 4 ★Nursing of At  28. Place of De  29. Place of De  20. Place of De  20. Place of De  20. Place of De  20. Place of De	1 Ye  24a. Was an autops perform 1 Yes 2 ath (Check only one- Home 5 Resides 28d. Describe how 28f. Location (St. City or Town) 2e, and due to the company t	pacco use contribute  as 2 ☑ No 3 ☐ F  24b. Were a prior to death?  1 ☐ Ye  a)  ance 6 ☐ Other (Sp  w injury occurred  ause(s) and manner and second	Day Year  to the cause of death?  Probably 4 Unknown autopsy findings available o completion of cause of as 2 No  Procify)  Bural Route Number, as stated.				
Be	Part II. Other significant conditions contrib	9 ☐ Unknown  puting to death but not result of the put not result	ER/Outpatient 28b. Time of Injury ome, farm, stree y)	Other (specify) erlying cause give  3 □ DOA Other 28c. Injury Work 1 □ N t, factory, office	26. Place of De  26. Place of De  27. 4 ★Nursing of At  28. Place of De  29. Place of De  20. Place of De  20. Place of De  20. Place of De  20. Place of De	1 Ye  24a. Was an autops perform 1 Yes 2 ath (Check only one- Home 5 Resides 28d. Describe how 28f. Location (St. City or Town) 2e, and due to the company t	pacco use contribute  as 2 ☑ No 3 ☐ F  24b. Were a prior to death?  1 ☐ Ye  a)  ance 6 ☐ Other (Sp  w injury occurred  ause(s) and manner and second	Day Year  to the cause of death?  Probably 4 Unknown autopsy findings available o completion of cause of as 2 No  Procify)  Bural Route Number, as stated.				
Medical Certification: To Be Completed by Phys	Part II. Other significant conditions contrib	pital: 1 Inpatient 2 28a. Date of Injury (Month, Day, Year)  28e. Place of Injury - At he building, etc. (Specification)	ER/Outpatient 28b. Time of Injury ome, farm, stree y)	Other (specify)  erlying cause give  3 DOA Other  28c. Injury Work 1 Do  at, factory, office  coccurred at the tin stigation, in my or	26. Place of De  27. 4 X Nursing   7 at  7 es 2 No  ne, date and place  2 number	1  Ye  24a. Was an autops perforn 1  Yes 2 ath (Check only one  28d. Describe ho  28f. Location (St. City or Town  2e, and due to the courred at the time, di	acco use contribute  as 2 No 3 F  24b. Were a prior to death? 1 Po No 1 F  and Point	Day Year  to the cause of death?  Probably 4 Unknown autopsy findings available completion of cause of s 2 No  Procify)  Rural Route Number, as stated. In the cause(s)				
Be	Part II. Other significant conditions contrib	pital: 1 Inpatient 2 28a. Date of Injury (Month, Day, Year)  28e. Place of Injury - At he building, etc. (Specification)	ER/Outpatient 28b. Time of Injury ome, farm, stree y)	Other (specify)  erlying cause give  3 DOA Other  28c. Injury Work 1 Do  at, factory, office  coccurred at the tin stigation, in my or	26. Place of De  27: 4 ★Nursing of At  7 / es 2 □ No  ne, date and place of De  inion, death occording of the Atlanta occording occordinates occording occordinates occording occordinates occordina	1  Ye  24a. Was an autops perforn 1  Yes 2 ath (Check only one  28d. Describe ho  28f. Location (St. City or Town  2e, and due to the courred at the time, di	acco use contribute  as 2 No 3 F  24b. Were a prior to death? 250 No 1 F  account of the prior to death? 1 Ye  a)  and prior to death? 1 Ye  a)  and prior to death? 1 Tye  and prior to death? 1 Tye  and prior to death? 1 Tye  account of the prior to death?  account of the prior to deat	Day Year  to the cause of death?  Probably 4 Unknown autopsy findings available completion of cause of s 2 No  Procify)  Rural Route Number, as stated. In the cause(s)				
Be	Part II. Other significant conditions contrib  25. Was case referred to medical examiner?  1   Yes   2   No	pital: 1   Inpatient 2   28a. Date of Injury (Month, Day, Year)  28e. Place of Injury - At ho building, etc. (Specificant of the basis of examina and manner stated.	ER/Outpatient 28b. Time of Injury ome, farm, stree y) wledge, death of tion and/or inve	Other (specify)  erlying cause give  3 □ DOA Other  28c. Injury Work 1 □ N  tt, factory, office  coccurred at the timestigation, in my open cause give  29c. License	26. Place of De  26. Place of De  27. 4 x Nursing I  28. Yes 2 No  29. No  20.	1  Ye  24a. Was an autops perform 1  Yes 2 ath (Check only one 28d. Describe ho  28f. Location (St. City or Town e.e, and due to the curred at the time, di	pacco use contribute  as 2 ⊠ No 3 ☐ F  by 24b. Were a prior to death? 1 ☐ Ye  by 10 ☐ 6 ☐ Other (Sp  w injury occurred  ause(s) and manner at and place, and du  god. Date signed (Mon)  December 2	Day Year  to the cause of death?  Probably 4 Unknown autopsy findings available completion of cause of s 2 No  Procify)  Rural Route Number, as stated. In the cause(s)				
Be	Part II. Other significant conditions contrib	pital: 1   Inpatient 2   28a. Date of Injury (Month, Day, Year)  28e. Place of Injury - At ho building, etc. (Specificant of the basis of examina and manner stated.	ER/Outpatient 28b. Time of Injury ome, farm, stree (y) wledge, death of tion and/or invention and/or inventi	other (specify)  erlying cause give  3 □ DOA Other  28c. Injury Work 1 □ N  t, factory, office  coccurred at the timestigation, in my operation of the coccurred of the timestigation of the coccurred of the timestigation.	26. Place of De  26. Place of De  27. 4 x Nursing I  28. Yes 2 No  29. No  20.	1  Ye  24a. Was an autops perforn 1  Yes 2 ath (Check only one  28d. Describe ho  28f. Location (St. City or Town  2e, and due to the courred at the time, di	pacco use contribute  as 2 ⊠ No 3 ☐ F  by 24b. Were a prior to death? 1 ☐ Ye  by 10 ☐ 6 ☐ Other (Sp  w injury occurred  ause(s) and manner at and place, and du  god. Date signed (Mon)  December 2	Day Year  to the cause of death?  Probably 4 Unknown autopsy findings available completion of cause of s 2 No  Procify)  Rural Route Number, as stated. In the cause(s)				

State Registra

State of Maryland / Department of Health and Mental Hygiene 2 43225 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Month Day **Physician** Elizabeth Alden Chase 5:55 p<sup>M</sup> December 28, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Hillhaven Nursing Center, Adelphi Prince George's Inc. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 □ M 2 🕱 F Director 189-24-7978 87 Sept. 27, 1921 New York Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location show 10b. County 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Modical Exeminer, ust be notified at Director 1 ☐ Yes 2 🛣 No Maryland Prince George's Adelphi 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3210 Powder Mill Road 20783 USA death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. within 72 hours after 1 ☐Yes 2 XI If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: White Specify: ₽ 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Attorney Federal Government permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygic Important: If item 27 is marked other i any injury or other traumatic event, In 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Merton Chase Catherine Mary Campbell ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1983 Maison Way, Carson City, NV 89703 Abigail C. Johnson/Niece Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 30, Dec. Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2008 Alexandria, Virginia 21. Signature of Funeral Service Licen 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring.MD 20901 Usa nevale 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Cardiomyorathy disease or condition resulting in death) years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine requires that the death certificate be executed and burial-trar Due to (or as a consequence of) Box 68760, attending physician Physician/Medical the as IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy for in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No P.0. the detached 9 Hunknown ģ signed | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate performe Division of Vital 1 ☐ Yes 1 ☐ Yes 2 ☐ No 2 No Physician: 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 A Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury 28b. Time of After 1 Certification: 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending (Month, Day, Year) 1 Natural 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No n 24 hours after death.

Be Funeral Director: A pletely filled in by the fi 2 Accident 6 Could not be determined 3 Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide TC Certifying Physician: To be best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier npletely (Check only one) the the within To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number ည D41978 December 30,2008 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nader Tavakoli, Md 4000 Mitchellville Road, A312, Bowie, Md 20716 31. Date filed (Month, Day, Year) Registrar's Signature State DEC 30 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2008 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav  $\mathbf{P}^{\mathsf{M}}$ Marylou Carroll 26, 2008 December 1:56 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 1 Duvall Lane Gaithersburg Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Hours 524-20-1999 1 □ M 2 😿 F 80 May 12. 1928 Arizona Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Montgomery Gaithersburg 1 ves 2 No 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? 1 Duvall Lane 20877 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🛛 No Specify: White 3 Widowed 4 XDivorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Communication Workers Elementary/Secondary (0-12) College (1-4or 5+) Union Representative of America 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Archibald Miller Martha Mardis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul R. Blevins (Nephew) Duvall Lane, Gaithersburg, MD 20877 20b. Place of Disposition (Name of Cemetery, crematory or other place)
Metropolitan
Crematory 20a. Method of Disposition 20c. Location - City or Town, State Date December 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia 2008 22. Name and Address of Facility DeVol Funeral Home, 21. Signature of Funeral Selving 10 East Deer Park Drive, Gaithersburg, MD 20877 23a. l'art 1 Enferthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot, in bear failure. List only one cause on each line. Approximate Interval Between Onset and Death disease or condition resulting in death) ENSIVE to (or as a conse elence of): 0,60 Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy ecedent pregnant past 12 months? s 2 100 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy Day Month Year 5 ☐ Other (specify) 9 Unknown known

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

10a. State

**Funeral** 

Director

show

Director

by Funeral

Completed

Be

ျှ

ir than "natural", or items 23a or 28a-f shov

permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 239 any injury or other traumatic event, the Marked Space.

Examine Physician/Medical Completed by Be

burial-trans and attending physician for use as the burial signed by the a should I page 2 s has certificate funeral

Certification: To After this To the Hospital or Auton.

within 24 hours after death.

To the Funeral Director: Aft

The law requires that the death certificate be executed

P.O. Box 68760,

Division of Vital Records,

or Attending

10

IF FEMALE:
 23b. Was de in the p 1 □ Yes 9 □ Un
 Part II. Other

Secrentially list can disast if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed 1 □ Yes 2 No 25. Was case referred to medical examiner?

1 X Yes 2 □ No 27. Manner of Death
1 Natural
2 Accident 5 Pending investigation 6 ☐ Could not be determined 3 Suicide 4 T Homicide

					26.	Place of Dea	th (C	heck only one)
ło	spital: 1 ☐ Inpatient 2 ☐	ER/Outpatient	3 □	DOA	Other:	I ☐ Nursing H	lome	5 Residen
	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury			injury at Work?			Describe how
			М		1 □Yes —	2 □ No		
	28e. Place of Injury - At h building, etc. (Speci	ome, farm, stree fy)	t, facto	ory, of	fice		28f.	Location (Stre City or Town,

ce 6 Other (Specify) injury occurred et and Number or Rural Route Number, State) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

11.	mariner stated.	
9b. Signature and title of certifier		
1000	m ome	1,1

29c. License number D 00428

29d. Date signed (Month, Day, Year) December 29, 2008

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

2101 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ivan Biecher MO DONE

State Registrar

Medical

DEC 3 0 2008

31. Date filed (Month, Day, Year)

		1	1 - For State Registrar	State of Ma	aryland	-	artment of F tificate of				~ ~	08	43227	
	Physici /Medic		1. Decedent's Name (First, Mid- Shirley M. Da	the					2. D N Dec	ate of Death Month ember	Day 28, 2	Year 008	3. Time of Death 04:13 A M	
	Examin		4a. Facility Name (If not instituti 123 Washingto	,			4b. City, Town, o				4c. County  Mont	y of Death	У	
	Funeral Director		5. Social Security Number 217–28–2054	6. Sex 1 □ M 2 🛣 F	e (In yrs. lasi	t birthday) Yrs.	If Under 1 Year Months Days	If Unde Hours	er 24 Hrs. 8. D Min. (A Jur	ate of Birth Month, Day, ne 13,	<sup>Year)</sup> 1931		place (State or Foreign htry) 1and	
	Maryland -f show	tor	Usual Residence of Decedent  10a. State  10b. Count  MD  Montp	-	10c. City, T	fown or Loo hersb						1	0d. Inside City Limits 1 ☐ Yes 2 🔼 No	
	h with the 23a or 28a st be notii	al Director	10e. Street and Number	<u> </u>	-		10f. Zip Code 208	77			g. Citizen of			
036	within 72 hours after death with the Maryland lene. than "natural", or items 23a or 28a-f show than "motical Evan incl. in the confilm of at	by Funeral	11. Marital Status  1 Never Married 2 Ma 3 2 Widowed 4 Divorce	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 ☑ N			Vas Decedent of H fYes, specify Cuba	dispanic C an, Mexic Specia		res or No- i, etc.)		ce - Americ ck, White,	etc.	
1215-0036	be filed within 72 ho ttal Hyglene. d other than "natur event, Ih. w. circul	Completed	15. Decede (Specify only high Elementary/Secondary (0-12)	est grade completed)  College (1-4or 5	<u></u>	(Give life. L	dent's Usual Occup kind of work done OO NOT use retired nty Admi	during me d)		F	6b. Kind of B		•	
		To Be C	17. Father's Name (First, Middle John Henry Ma		1			18. Mot	ther's Name <i>(Firs</i>		aiden Surnar	ne)	<u> </u>	
e, Mar	l and 2 sho lealth and im 27 is m iher traum		19a. Informant's Name/Relation Francis Carl		nion)	123		on G	rove Lan	ne Gai	thersb	urg,	MD. 20877	
Saltimor	permit. Pages 1 Department of I Important: If ite any injury or ot once.		20a. Method of Disposition  1X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (  21. Signature of Funeral Service			Linco	sition (Name of natory or other place In Cemet . Name and Addre	ery		2   :	Oc. Location  Brentw	ood,		
D D	Department of the second of th		23a. Part 1. Enter the disease,	. Day	the death	10	East De	er P	ark Driv	re Gai	thersb		MD 20877 Approximate	
	Physician /Medical Examiner		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Sarcoma  Due to (or as a consequence of):											
	rinicate be executed ng physician and as the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Closade or Injury that initiated events resulting in death) Last	b										
O. DOX 00	To the rospital or Attending Prysician: The law requires that the death certificat within 24 the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒No 9 □ Unknown	23c. If yes, outcome  1  Live birth 4  Pregnant at 9  Unknown	2 Fetal de	ath 3□	Ectopic pregnanc	y				ate of deliver	ery Day Year	
cords, r	equires that en signed b	þ	Part II. Other significant condit	lions contributing to death bu	ut not resultin	ng in the un	derlying cause giv	en in Par	t I. 2		acco use cont s 2 □ No		ne cause of death? eably 4 🗆 Unknown	
ין שבני	cate has be page 2 sho	Completed								4a. Was an autopsy performe □Yes 2	ed?	prior to con death?	psy findings available mpletion of cause of 2 ANo	
	ysician s certifi director	o Be	25. Was case referred to medic examiner? 1 ☐ Yes 2 🖾 No	Hospital:	nt 2□ER	Outnation	+ 3 DOA Oth		ce of Death (Che			nos (Ci		
	ending Fin ath. or: After thine funeral		27. Manner of Death 1   ↑ Natural 5 Pend 2 Accident inves	28a. Date of Injur ing (Month, Day tigation	ry 28	b. Time of Injury	28c. Injur Worl	y at	28d. C		v injury occur		y)	
ואר ביינול אוריים אינויים אינו היינוים אינוים אינויים	to one noopstal or Attending Prysician; The lat within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Certification:	4 🗆 Hornicide	mined 286. Place of Inju- building, etc	c. (Specify)				C	ity or Town,	State)		l Route Number,	
:	tne nos hin 24 ho the Fune upletely f	Medical	(Check only 2 Medica	ing Physician: To the best of Il Examiner: On the basis of and manner sta	f examination	age, death and/or inv	estigation, in my o	pinion, d	eath occurred at	the time, dat	te and place,	and due to	the cause(s)	
	Son Son	2	29b. Signature and live of certifi	er ev		>	29c. Licens D458		r		d. Date signe	,		
			30. Name and address of person Leon Hwang M.					, MD	. 20850					
	Sta Registra		31. Date filed (Month, Day, Year DEC 3 0	r) Registra	ar'a Cianatura	- 61								
DHA	H 17 Rev 1/20	201				A								

DHMH 17 Rev 1/2001

			1 - State of Ma Registrar	•	rtment of Health a tificate of Death		glene leg. No.2008 43228
ı	Physicia	an	1. Decedent's Name (First, Middle, Last)  James E. Talmage Deane			2. Date of Dear Month	Day Year
	/Medic Examin	cal	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of	December Death	27 24, 2008 11:00P <sup>M</sup> 4c. County of Death
	Examin	ier	9645 Adams Willett Road		Nanjemoy		Charles
ŧ	Funeral Director		224-20-3042 1\(\overline{\mathbb{R}}\) \\^2 \subseteq \(\overline{\mathbb{R}}\) \\\^2 \subseteq \(\overline{\mathbb{R}}\) \\\\^2 \subseteq \(\overline{\mathbb{R}}\) \\\\\ \overline{\mathbb{R}}\) \\\\\ \overline{\mathbb{R}}\) \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	(In yrs. last birthday) 83 Yrs.	If Under 1 Year   If Under 24 Months Days Hours	Hrs. 8. Date of Birth Min. (Month, Day June 2)	9. Birthplace (State or Foreign Country) Virginia
	land ow		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Loc	eation		10d. Inside City Limits
	a-fsh	ctor	MD Charles	Nanjemo	у		1 □ Yes 2 No
	vith th	Dire	10e. Street and Number 9645 Adams Willett Road		10f. Zip Code <b>20662</b>	1	0g. Citizen of What Country?
	ns 23	Funeral Director	11. Marital Status 12. Was Decedent E	ver in U.S. 13. V	Vas Decedent of Hispanic Origi Yes, specify Cuban, Mexican,	n? (Specify Yes or No-	14. Race - American Indian,
5-0036	be filed within 72 hours after death with the Maryland that Hygiene.  Id other than "natural", or items 23a or 28a-f show event, its Marieal Exprining in that be recalled at	þ	Armed Forces?  1 □ Never Married 2 ➡ Married  3 □ Widowed 4 □ Divorced Year or Dates:	o l	Yes, specify Cuban, Mexican,  Yes 2 No Specify:	⊇uerto Rican, etc.)	Black, White, etc.  Specify: White
	72 ho "natur	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	ent's Usual Occupation kind of work done during most o DO NOT use retired)	f working	16b. Kind of Business/Industry
7	within iene. than than	dwo	Elementary/Secondary (0-12) College (1-4or 5+	-1	no NOT use retired) hanic		Sheet Metal/Construct
מ		Be C	17. Father's Name (First, Middle, Last)			Name (First, Middle, I	
yland	2 should be and Menta is marked aumatic ev	2	Eli Edward Deane			Mae Breede	
Ma	がもとす		19a. Informant's Name/Relationship (Type. Print)  Cora Deane/Wife		Adams Willett		r, City or Town, State, Zip Code)
e,	is 1 and of Health item 27 other t		20a. Method of Disposition	20b. Place of Dispos			20c. Location - City or Town, State
Baltimor	Page ment cant: If		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Maryland	Veterans Cem.	1/9/2009	Cheltenham, Maryland
e n	permit. Pages 1 and Department of Heal Important: If item 2 any injury or other once.		21. Signature of Funeral Service Licensee 1009	40	Name and Address of Facility Arehart—Echols		-
	Physician /Medical Examiner			9.	or the mode of dying, such as co	ardiac or respiratory arr	est, Approximate Interval Between Onset and Death
oo,	tificate be executed g physician and as the burial-transit	al Examiner	causé. Enter Underlying Cause (Disease or injury that initiated events c	consequence of):			
09/90	ficate physisthe t	edical	d				
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at 9 □ Unknown	Petal death 3 ☐	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
ras, r.	juires that t n signed by Ild be detac	by	Part II. Other significant conditions contributing to death but	t not resulting in the un	derlying cause given in Part I.		pacco use contribute to the cause of death?
Records,	The law rec te has bee age 2 shou	Completed				24a. Was a autops perforr	y prior to completion of cause of ned? death?
	clan: ertifica ector, p	Be C	25. Was case referred to medical examiner?		26. Place o	1 □ Yes 6 f Death <i>(Check only on</i>	2 <b>T</b> No 1 □ Yes 2 □ No e)
5	Physic this c	၉	Hospital:	t 2 ☐ ER/Outpatient			ence 6 Other (Specify)
VISION OF	ding th: : After : funer	rtion	TS Natural 5 Pending (Month, Day, 2 Accident investigation	Year) 200. Time of Injury	28c. Injury at Work? M 1 □ Yes 2 □ No		ow injury occurred
	of the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, p	Certification:	a Could not be	ry - At home, farm, stre (Specify)	et, factory, office	28f. Location (St City or Town	reet and Number or Rural Route Number, n, State)
	ne Hospitt n 24 hours ne Funera pletely fille	Medical C	29a. Certifler (Check only one)  Certifying Physician: To the best of and manner state.	examination and/or inv	occurred at the time, date and estigation, in my opinion, death	place, and due to the c occurred at the time, d	ause(s) and manner as stated. ate and place, and due to the cause(s)
	To th To th Comp	Me	29b. Signature and title of certifier		29c. License number	2	9d. Date signed (Month, Day, Year)
			M Matter		0783	5 7	12/26/05
B	BAI		30. Name and address of person who completed cause of de	1703	Print) Krishan I	fathur, M.D.	20646
	Sta Registra		31. Date filed (Month, Day, Year)  DEC 2 9 2008  32. egistrar	r's Signature	celes		

Derrickson, Andrew

•	ugh
	8

			For State Registrar		State o	of Maryla		artment of I rtificate of					2008	4	3229
			1. Decedent's Name	(First, Middle	e, Last)						2. Date of De	eath			ne of Death
	Physicia /Medic		Andrew C	harles	Derricks	on, Sr	•				Decemb	oer	20 200	8 8:	MAOO:
The same	Examin		4a. Facility Name (If					4b. City, Town, o	r Locatio	n of Death		4c.	County of Deat	h	
			Berlin Nu					Berlin		or DA Hro			Worce		
	Funeral		5. Social Security Nu		6. Sex 1 ☑ M 2 ☐ F		s. <i>last birthday</i> ) Yrs.	If Under 1 Year Months Days			8. Date of Bir (Month, Da	a <i>y</i> , Year)			tate or Foreign
	Director		220-26-29 Usual Residence of			83				<u> </u>	Dec 23,	192	24	_MD	
	aryland show			10b. County		10c. C	City, Town or Lo	ocation						10d. Insid	de City Limits
	a-fsl	ctor	MD	Worce	ester	Be	erlin							1 3	Yes 2 No
	ith the M or 28a-f	Dire	10e. Street and Num		_			10f. Zip Code				10g. Cit	izen of What Co	untry?	
	filed within 72 hours after death with the Maryland Hygiene. wther than "natural", or items 23a or 28a-f show ent, the Medical Everyment met be notified.	Funeral Director	9639 Seal	nawk Ro				21811					USA		
	er de item	-un-	11. Marital Status	nd OF More	Armed F	edent Ever in lorces? 2 No	U.S. 13.	Was Decedent of I If Yes, specify Cub	an, Mexic	origin? (Spe can, Puerto I	Rican, etc.)	0-	14. Race - Ame Black, White		ın,
36	irs aft	by F	1 ☐ Never Marrie 3 ☐ Widowed		If Yes, G Year or I	ive T		1 □ Yes 2 🔀 No	Speci	ify:			Specify: Bl	.ack	
21215-0036	72 hours after death w "natural", or items 23a	Completed		15. Deceden			16a. Dece	dent's Usual Occup	pation	ant of warking	2.7	16b. K	ind of Business/	Industry	
21	thin 7 ie. an "n	nple	Elementary/Secon		st grade completed) College (	1-4or 5+)	life.	kind of work done DO NOT use retire	nd)		ig		_	_	
	ed wil	S	9t1					Self Emp	, <del>_</del> _				Seafo	od_	
pu	be file	Be	17. Father's Name (								(First, Middle	, Maiden	Surname)		
3	nould d Mer narke	2	Cyrus Dei				40h Maili	ng Address (Street	1	ah Sta		or City	Tawa Chata	Zin Codol	
Maryland	d2st than 7 is r traur	- 5	19a. Informant's Na Mary Eller			fo		Seahawk						zip Code)	
	s 1 and 2 should be filed within 72 hours after death with the Maryls f Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f shoother traumatic event, the Medical Eventions of the count		20a. Method of Disp		LCASOII/ WI		Place of Disp	osition (Name of	- :		ate		ocation - City or	Town, Sta	te
JO L	ages ent of nt; If i		1 ⊠ Burial 2 ☐ 4 ☐ Donation		3 Removal from		-	matory`or other pla 's Cemete	· '	12/26	/2008	Por	lin, MD		
Baltimore,	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, Item Monce.		21. Signature of Fur			, ot	2	2. Name and Addre	ess of Fac	cility			. т.т.т., т.т.	<u>'</u>	
ä	Depar Impor any ir		Talan	abt	tabox		1	ewis N. W 618 West	Rd.,	n Fune Salis	eraı Ho sbury,	ome MD 2	1801		
			23a. Part 1. Enter th	ne disease, or rt failure. List	complications that only one cause on	caused the dea									l Between
-	Physician		Immediate Cause (I	Final	A -	CVD								Onset	and Death
	/Medical Examiner		resulting in death)		Due to	(or as a conse	equence of):								
	LAMITIMES	<u>,</u>	Sequentially list con	iditions,	b	(or as a conse	oguenee of								
	ted nsit	Examiner	If any, leading to imr cause. Enter Under Cause (Disease or that initiated events	mediate rlying injury	Due to	(or as a conse	equence or,								
	execu n and al-tra	Exar	that initiated events resulting in death) L	.ast	c	(or as a conse	equence of):								
68760,	icate be executed physician and the burial-transit	edical			d										
	rtificar ng phy as th	<b>l</b> edi	15 55111 5									1	-		-
Box	eath certific attending p for use as f	an/N	IF FEMALE: 23b. Was decedent			itcome of preg birth 2□Fe		☐ Ectopic pregnan	cv			1	23d. Date of de	-	Year
O. E	e dea the at ned fo	Physician/M	in the past 12 t 1 ☐ Yes 2 ☐ 9 ☐ Unknown		4 ☐ Preg 9 ☐ Unk	gnant at time o nown	f death 5	Other (specify)					MOHIII	Day	real
σ.	uires that the de signed by the a d be detached f		Part II. Other signifi	icant condition	ons contributing to d	leath but not re	esulting in the u	inderlying cause giv	ven in Par	rt I.	23e. Did	tobacco i	use contribute to	the cause	e of death?
of Vital Records,	signe d be	d by	. a.v o a.v. o ig.i.i.i				· · · · · · · · · · · · · · · · ·	, , , , , , , , , , , , ,			1 🗆	Yes 2	□ No 3□ Pi	obably <b>u</b>	1 Unknown
00	w requir been s should	Completed	_								24a. Was	an	24h Were au	itonsy find	ings available
Re	sician: The law certificate has t irector, page 2 s	ш			•			<del></del>			auto	psy ormed?	prior to death?	completion	of cause of
ta	an: T tificat or, pa		25. Was case referr	ed to medica					26 Pla	ace of Death	1 ☐ Yes	2□Mo one)	1 □Yes	2 🗆 No	)
<u>&gt;</u>	ding Physician: The n. After this certificate h. funeral director, page	o Be	examiner? 1 ☐ Yes 🛂 🖸	No	Hospital: 1	Inpatient 2	☐ ER/Outpatie	nt 3 DOA Ott				,	6 □Other (Spe	cify)	
0 (	ng Ph ter th neral	Ī.	27. Manner of Death	n 5 ☐ Pendin	28a. Date	e of Injury nth, Day, Year)	28b. Time o	of 28c. Inju	ıry at rk?		28d. Describe				
<u>.</u>	endir sath. or: At	ätic	2 Accident	investi	gation			M 1 🗆	Yes 2	□No					
Division	or Attending Physician: The law requires that the death certificate be executed after death.  Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit	Certification: To	3 ☐ Suicide 4 ☐ Homicide	determ	inod 28e. Plac	e of Injury - At ding, etc. <i>(Spe</i>	home, farm, st c <i>ify)</i>	reet, factory, office		2	28f. Location ( City or To	(Street ar wn, State	nd Number or Ru e)	ural Route	Number,
	pital ours a eral D		29a. Certifier •	Cartifyin	ng Physician: To th	e heet of my k	nowledge dea	th occurred at the t	time date	and place	and due to the	cause(s	and manner a	e etated	
	24 hos Punetely	Medical			Examiner: On the										use(s)
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Me	29b. Signature and	title of certifie				29c. Licen	se numbe	er		29d. Da	te signed (Mont	h, Day, Ye	ar)
			> YMR	Mal	je.			DG	3199	9,		121.	23/200	8.	
	USN		30. Name and a dre	ess of person	who completed cau	se of death (It	em 23a) (Type	Print)					-		
	11		YOGESH		HRA 614	EAST	orn s	HORE DI	R.,	SAUSI	BURY	MD	21804		
	Sta		31. Date filed (Mont	-	2002	Hogistrar's Sig	nature	HOLE DI	-		(	(		1	
	Registr	ar	L U	EC 3 1	2008		N 19								

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If then Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modest Examiner must be notified at once.

Baltimore, Maryland 21215-0036

**Physician** /Medical Examiner

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlat-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

	-	For State Registrar AM	NC#5perINF	State of Ma 1/7/09,BM,M	-	-	rtment of F tificate of			al Hygle Reg.		0 -	40200
hysicia	an.	1. Decedent's Name	e (First, Middle, La	st)					Mo	te of Death	Day Yea	ır	Time of Death
/Medic		Joseph B					Ab City Town	. I continu		ember	26, 2008		:45 P M
Examin	er	· ·		e street and number) comery Host	nice		4b. City, Town, c		or Death		Montgome		
uneral				Sex 7. Ag	e (In yrs. last b	irthday)	If Under 1 Year Months Days		24 Hrs. 8. Dat		-		(State or Foreign
rector		5. Social Security N 181 – 14 – 181 14 9	32329	⊠M 2□F	86	Yrs.	Months Days	Hours	Mar	ch 10,	1922 Pe	ennsy	lvania
M		Usual Residence of 10a. State	Decedent 10b, County		10c. City, To	wn or Loc	ation					10d. lr	nside City Limits
f sho	tor	MD	Montgome	erv	Rockville							1	¥ Yes 2 No
r 28a	Director	10e. Street and Nur					10f. Zip Code			10g	. Citizen of What	Country?	
23a o ıst be	alD	1015 Gil	bert Road	i			2085	1		United States			s
or items miner mu	/ Funeral		ied 2 <mark>√</mark> Married	12. Was Decedent Armed Forces?  1 12 Yes 2 1	107.7. If Yes, specify Cuban, Mexican, Puerto				n, Puerto Rican,	pecify Yes or No- o Rican, etc.)  14. Race - American Indian, Black, White, etc.  Specify: White			
atural", cel Exa	ted by	3 Widowed	15. Decedent's E	Year or Dates:	16a. Decedent's Usual Occupation						16b. Kind of Business/Industry		
han "n	Completed	Elementary/Seco	ondary (0-12)	College (1-4or 5					_	I	ontgomer ublic So	-	-
nt, th	CO	17. Father's Name	(First Middle Last	5+	H	High School Principal.  18. Mother's Name (First, Mic							
ked o	o Be	Frank Good Veronica Shifko									,		
s marl	F			(Type. Print)	19	19b. Mailing Address (Street and Number or Rural Route Number, City						e, Zip Cod	le)
27 is ertra		19a. Informant's Name/Relationship (Type. Print)  Helen L. Good (Wife)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 2 1015 Gilbert Road Rockville, MD. 20851											
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modical Examiner must be notified at once.		20a. Method of Disposition  1XI Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  Gate of Heaven Cem.  20c. Location - City or Town, State  Dec. 31  Silver Spring, MD											
Importa any Inju once.		21. Signature of	ineral Service Lice		'				ity DeVol l		1 Home	, MD	20877
		23a Part 1. Enter t	the disease, or com	plications that caused one cause on each lir	the death. Do							App	roximate rval Between
sician	E Y	Immediate Cause disease or condition	(Final	Sepsis								Ons	set and Death
edical miner		resulting in death)	(	Due to (or as	a consequence			_	<i>-</i> 1	27 1			
	ē	Sequentially list co	nditions,		atic Sq		us Cell	Cance	er of the	e Neck			
ansit	Examiner	Sequentially list conditions, if arry, leading to immediate cause. Enter Underlying Cause (Disease or injury that imitated events											
physician and the burial-transit		resulting in death) Last Due to (or as a consequence of):											
physics the b	edical	d											
ttending or use as	ian/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy Month										delivery Day	Year
by the a	Physician/M	1 □Yes 2 l 9 □ Unknown	□No	4 ☐ Pregnant a 9 ☐ Unknown	t time of death	5⊔	Other (specify) _						
n signed	þ	Part II. Other signi Hyperte		contributing to death b	ut not resulting	in the un	derlying cause gi	ven in Part	I. 23		cco use contribute 2 ☐ No 3 ☐		
as bee 2 sho	Completed	Intra C	erebral I	Bleed with	CSF Sh	unt			24	la. Was an autopsy	24b. Were	autopsy fi	indings available tion of cause of
cate h page	Com								11	performe ⊒Yes 2 <b>1</b>	d? I death	? ′es 2⊠	
certifi ector,	Be	25. Was case referexaminer?		Hospital:			o Door Oth	oor:	e of Death (Chec				77
r this aral dir	7: To	1 ☐ Yes 2 🛣 27. Manner of Deat		1 ☐ Inpatie	ent 2 ER/0	Outpatient  Time of	3 ☐ DOA ☐	4 LI N			e 6 20ther (S	pecify)	Hospice
: Afte	atior	1 🏻 Natural 2 ☐ Accident	5 ☐ Pending investigation	(Month, Da n	y, Year)	Injury	Wor	ńk? ]Yes 2.[	]No				
d in by th	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined		ury - At home, c. (Specify)	farm, stre	et, factory, office		28f. Lo	cation (Streety or Town, S	et and Number or State)	Rural Rou	ute Number,
To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical C	29a. Certifier (Check only one)		hysician: To the best miner: On the basis o and manner st	f examination								
To th	Me	29b. Signature and	title of certifier	~	1		29c. Licens	se number		29d	. Date signed (Mo	onth, Day,	Year)
+1		M.D					D0065024 De					27, 2	800
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Monique Goma M.D. 6001 Muncaster Mill Road Rockville, MD. 20855											
Cto	to	Monique 31. Date filed (Mor						CKV11	rre, MD.	20833			
Sta Registr			FC 3 0 20		RA.	Mos	the same						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 8 Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Eugene Clarence Glanzer December 2008 9:30 a M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 907 Heather Avenue Takoma Park Montgomery 8. Date of Birth (Month, Day, Yea Dec. 30, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Year) Months 1 🏻 M 2 🗆 F 579-10-2653 95 1912 South Dakota Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, it is invided Event in a most once. 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director 1X Yes 2 No Takoma Park Maryland Montgomery 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? 20912 USA 907 Heather Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1∐Yes 2∭TNo Specify: White ۾ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Logo/Sign Painter Painting 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Peter Glanzer Katie Kilbauch ပ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8014 Barron Street, Takoma Park, MD 20912 Elisabeth Ann Wear/Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 29, 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Dec. 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 2008 Alexandria, Virginia 21. Signature of Funeral Service License 22. Name and Address of Facility Francis J. Collins Funeral Home Inc 500 University Blvd. W., Silver Spr Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Arrhythmia /Medical Due to (or as a consequence of): Examiner Cardiomyopathy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician and for use as the burial-transit Exami Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) cate has been signed by the a page 2 should be detached to ☐Yes 2☐No 9 Unknown 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Atrial Fibrillation, Dementia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2**X** No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5XXResidence 6 Other (Specify) 2**√** No 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

The law requires that the death certificate be executed of Vital Records, this certificate To the Hospital or Attending Physician: After thi Division within 24 hours after death

To the Funeral Director: /
completely filled in by the f

Baltimore, Maryland 21215-0036

Box 68760,

P.0.

State Registrar

Medical

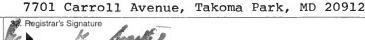
Nasreen Kango, 31. Date filed (Month, Day, Year) DEC 30 2008

of certifier

29a. Certifier

(Check only one)

29b. Signature and title



and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD



炻 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

	,	-	For State Registrar	State of Maryland / I		tment of He ficate of D		Re	g. No. 200	8	43232
ı.	Physicia	_	1. Decedent's Name (First, Middle, La Agatha	st) Herry				Date of Death	, <sup>D</sup> 27008 Y	ear	3. Time of Death 0100 M
	/Medic Examin	CMS.	4a. Facility Name (If not institution, giv	e street and number) Ventist Hospit		b. City, Town, or I	Location of Death		4c. County of		rv
	Funeral Director		5. Social Security Number 6. S		irthday)		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 9 / 1 8 / 1		. Birthp	ace (State or Foreign try) nada
	Maryland f show ied at	tor	Usual Residence of Decedent  10a. State 10b. County  MD Prince	George's 10c. City, Tow		ion 7ille				10	0d. Inside City Limits 1 ☐ Yes ※ No
	th with the I 23a or 28a- ist be notif	Funeral Director	10e. Street and Number 6305 Riggs Roa	ıd		10f. Zip Code 207	83	10	Og. Citizen of What Grena	da	
030	be filed within 72 hours after death with the Maryland tral Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:			spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Black, Specify:	White,	
1215-0036	within 72 ho iene. than "natur the Mrdical E	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)		(Give kir life. DO	nt's Usual Occupa nd of work done do NOT use retired) nemaker	tion uring most of work	ing	16b. Kind of Busir		
yland z	uld be filed Mental Hygir rked other tic event, the	To Be Co	17. Father's Name (First, Middle, Las George Barthol	Lomew				Thompso	on		
Mar	and 2 shore ealth and N 27 is ma		19a. Informant's Name/Relationship Victor Herry	Son 6	5305	Riggs		attsvil	lle,Mar	yla	nd 20783
Baltimore,	of H fiter		20a. Method of Disposition  1	Themoval from State   C+ Cc	eorge	ion (Name of atory or other place es Cem.	1/05	/2009		ges	,Grenada
Ball	permit. Pag Department Important: I any Injury o		21. Signature of unexal Service Lio	inelle	924	41 Colu	RTNALDI mbia Bl	vd.Silv	ver Spr		, P.A. , Md20910 Approximate
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	nplications that caused the death. Do y one cause on each line.  a	HCI	ery C	) (Sec )	or respiratory arre			Interval Between Onset and Death
3	ecuted ind transit	Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence  Due to (or as a consequence							
8760,	ficate be executed physician and s the burial-transit	dical E	Todaling in dealiny East	d.	e oi).						
O. Box 6	death certi e attending d for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2   □ Unknown	23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 9 ☐ Unknown		Ectopic pregnancy Other (specify)			23d. Date Monti		ery Day Year
О.	The law requires that the de tte has been signed by the a vage 2 should be detached f	þ	Part II. Other significant conditions	contributing to death but not resulting	in the und	lerlying cause give	en in Part I.	23e. Did tol			he cause of death? bably 4 □Unknown
Vital Records,	The law reate has bee	Completed						24a. Was a autops perfori 1∐ Yes	sy pri- med? de	or to co ath?	psy findings available mpletion of cause of
	siclan: Th certificate irector, pag	Be	25. Was case referred to medical examiner? 1 ☐ Yes 21 No	Hospital: 1 X Inpatient 2 ☐ ER/C	Outpatient	3 DOA Othe	26. Place of Dea		<i>e)</i> ence 6 □Other	(Specif	
n or	ding Phys J. After this funeral di	on: To	27. Manner of Death 1 ☑ Natural 5 ☐ Pending		Time of Injury	28c. Injun Work	/ at		ow injury occurred		<i>y</i> /
Division or	Atten r death ector: by the	Certification:	2 Accident investigati 3 Suicide 6 Could not 4 Homicide determine	be 280 Place of injury - At home	farm, stree		Yes 2 No	28f. Location (S City or Town	treet and Number n, State)	or Rura	al Route Number,
	To the Hospital or within 24 hours affer To the Funeral Dircompletely filled in	Medical (	29a. Certifier / 1 Certifying I	Physiclan: To the best of my knowled aminer: On the basis of examination and manner stated.	lge, death and/or inve	occurred at the tinestigation, in my o	ne, date and place pinion, death occu	, and due to the or rred at the time, or	cause(s) and mandate and place, ar	ner as s nd due t	stated. the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier			29c. License 5 9	number 428	2	29d. Date signed	(Month,	Day, Year)
			30. Name and address of person when 2000 and address of person address of pe	completed cause of death (Item 23a 7605 32 Registrar's Signature	Car	WI Au	e Tako	ma le	ark, N	10	20912
	St Regist	ate rar	46 400 0	108 listers H.	Span	de la company de					

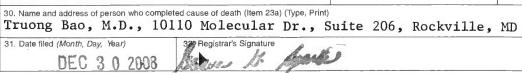
State of Maryland / Department of Health and Mental Hygiene

			For State of Maryland / Department of Health and Maryland / Department of Health / Department / D		eg. No. 2001	8 43233
	Physicia	an		2. Date of Deat Month	h Day Year	3. Time of Death
74	/Medio		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	Dec. 2	25 2008 4c. County of Dea Montgo	10:30PM
* معد	Funeral	2	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day,		thplace (State or Foreign
	Director		248-66-0708 1 Months Days Hours Min.  Usual Residence of Decedent	Oct.23	3,1938 S.	Carolina
	aryland show	-	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits 1 X Yes 2 □ No
	h the M	irecto	10e. Street and Number 10f. Zip Code	1	0g. Citizen of What Co	ountry?
	eath wit	Funeral Director	12900 Falling Waters Cir #102 20874  11. Marital Status 12. Was Decedent Ever In U.S. 13. Was Decedent of Hispanic Origin? (Spe	cify Yes or No-	U.S.A	· · · · · · · · · · · · · · · · · · ·
9800	ours after d ral", or item Examinat	by	11. Marital Status  1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced  12. Was Decedent Ever In U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 □ No If Yes, Give Year or Dates:  13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto F 1 □ Yes 2 □ No Specify:		Black, Whit	e, etc. ack
21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examinar must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) 9th  16a. Decedent's Usual Occupation (Give kind of work done during most of workin life. DO NOT use retired) Bus Attendant	ng	Montgome Public	ry Co.
/land 2	should be filed ind Mental Hyg s marked other umatic event,	To Be C	17. Father's Name (First, Middle, Last) Elijah Huggins Sr  18. Mother's Name Hattie		Maiden Surname) Porter	
Mar	sho s m		19a. Informant's Name/Relationship (Type. Print)  Sheila Huggins- Wife  19b. Mailing Address (Street and Number or Rural 12900 Falling Water			
Baltimore, Maryland	Pages 1 and 2 nent of Health ant: If item 27 i ury or other tra				20c. Location - City or Germanto	
Balt	permit. Pages Department of Important: If it any injury or o	-	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Snc			
~~	Physician		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart faddre. List only one cause on each line.  Immediate Cause (Phal disease or condition)  PNEUMONIA			Approximate Interval Between Onset and Death
	-/Medical Examiner		resulting in death)  Due to (or as a consequence of):			
A	uted 1 Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):			
68760, 🗆	rificate be executed ig physician and as the burial-transit		that initiated events resulting in death) Last  C. Due to (or as a consequence of):			
		Medical	IF FEMALE:			
P.O. Box	The law requires that the death cert ate has been signed by the attendin age 2 should be detached for use	Physician/N	23b. Was decedent pregnant in the past 12 months?  1		23d. Date of de Month	livery Day Year
	w requires that been signed b should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Stroke, Severe Protein Malnutrition		oacco use contribute to	o the cause of death?
Division of Vital Records,		Completed		24a. Was a autops perforr 1 □Yes	ned? prior to death?	utopsy findings available completion of cause of
Vita	Physician: The this certificate   al director, pago	Be (	25. Was case referred to medical examiner?  Hospital: 17. Other: 0.000	(Check only on	e)	
ō	his di	n:To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 2		ence 6 Other (Spe ow injury occurred	cify)
sion	I or Attending Physician: after death. I Director: After this certification by the funeral director, I	catio	1 ☐ Matural 5 ☐ Pending (Month, Day, Year) Injury Work? 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	201 11 12		
Ω	tal or Al	Certification: To	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	City or Town	reet and Number or R n, State)	ural Houte Number,
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	Medical (	29a. Certifier (Check only one)  1 **XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, a 2 **Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.			
		Me	29b. Signature and title of certifier  29c. License number  D6 4 4 1 3	2	9d. Date signed (Mont	
	3		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			
	Sta	to	Juanita L. Smith, MD 9901 Medical Center Dr Ro	ckvil	le, MD 20	850
	Registr		DEC 3 0 2008 Some & South			

			For State Registrar	State of Marylan		artmen ertificate				Reg	-	008	4323	
	Physicia		1. Decedent's Name (First, Middle, Last Clark A.	douston						Date of Death Month ecember	<sup>D</sup> 2 <sup>y</sup> 2,2	008ar	3. Time of Death 11:00 р м	
	/Medic Examin		4a. Facility Name (If not institution, give Manor Care of Che		4b. City, Town, or Location of De Chevy Chase						4c. Count	y of Death	у	
	Funeral Director		5. Social Security Number 6. S 413-54-2610	ex 7. Age (In yrs. 73	last birthday Yrs.	) If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. 8. E Min. Se	pate of Birth Month, Day, Yes pt. 19	,1935	9. Birthp Kans	lace (State or Foreigr try) as	
		ector	Usual Residence of Decedent  10a. State 10b. County  DC N/A  10e. Street and Number		y, Town or L		Code			100	Citizen of	10 What Coun	0d. Inside City Limits 1  Yes 2 No	
diw di	23a or	al Dir	5225 Connecticut	Avenue, NW #61	4		2001	1.5		-		State	-	
Q Z I Z I 3-UU30 filed within 72 hours often death with the Manuland	ntal Hygiene. ed other than "natural", or items 23a or 28a-f show event, it a Medical Examinar must be notified at	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☒Divorced	12. Was Decedent Ever in U Armed Forces? 1	S. 13	. Was Deced If Yes, spec 1 □ Yes 2		lispanic Orig an, Mexican Specify:	gin? (Specify , Puerto Rica	Yes or No- n, etc.)		ace - American Indian, ack, White, etc. Black		
)-c::	n "natur Jedical	Completed	15. Decedent's Ed (Specify only highest gra	de completed)	(Giv	edent's Usua e kind of wor DO NOT us	k done d	during most	t of working	16	b. Kind of E	Business/Inc	lustry	
Z 1 Z	al Hygiene. other than ' vent, It e Ite		Elementary/Secondary (0-12)	College (1-4or 5+) 5+	Sch	ool Pr	inci	-		D rst, Middle, Mai			School School	
_	= 0 2	To Be	17. Father's Name (First, Middle, Last) Clement M. Hous						a March		den Surnar	ne)		
, Mary	Department of Health and Mental Important: If them 27 is marked on any injury or other traumatic evonce.	7 (1)	19a. Informant's Name/Relationship (*) Kondra R. White	Type. Print) (niece)	11					oute Number, C Lchmond				
Tore,	nt: If item ry or othe		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specif	Removal from State		position (Name matory or of ke Cre		e)	Date 12/30/0			- City or To		
Baltimol	Departm Importar any injur		21. Signature of Funeral Service Licensee  22. Name and Address of Facility McGuire Funeral Service  7400 Georgia Avenue, NW, Washington DC											
	nysician	6 10	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	olications that caused the deat	h. Do not e	nter the mod	e of dyir	ng, such as	cardiac or res	spiratory arrest			Approximate Interval Between Onset and Death	
	Medical xaminer		resulting in death)	Due to (or as a conseq	uence of):	SNG	C	An	A (CEX	_				
2	d ansit	Examiner	Sequentially list conditions, if any, earling to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consec								134		
ste be evacuted	pri j	ā	d d											
I Records, P.O. Box 687 The law requires that the death certificate	/ the attending p	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn. 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of 6	death 3	☐ Ectopic pi ☐ Other (sp		у				ate of delive	ry Day Year	
dS, T.	been signed by the should be detached	þ	Part II. Other significant conditions of	ontributing to death but not res	ulting in the	underlying ca	ause giv	en in Part I.					e cause of death?	
Hecords,	ite has been age 2 should	Completed					- 11			24a. Was an autopsy performe	24b.	Were autoprior to cordeath?	osy findings available inpletion of cause of	
VITAL	ector, p	Be	25. Was case referred to medical examiner?	Hospital:			Oth			neck only one)			2 1110	
OT OF	er this eral dir	n: To	1 ☐ Yes 2 ☐ No  27. Manner of Death	1 ☐ Inpatient 2 ☐  28a. Date of Injury (Month, Day, Year)	ER/Outpati 28b. Time Injury		8c. Injur	4) Z NU		5 Residence Describe how			/)	
IVISION	within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 s	Certification:	1 SMatural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		ome, farm, s	М	1 🗆	Yes 2∐1	28f. I	Location (Stree City or Town, S	et and Num State)	ber or Rura	l Route Number,	
U Sletinsot	4 hours a cuneral C		(Check only 2 Medical Exar	ysician: To the best of my kno niner: On the basis of examina										
To the	within 2  To the I  complet	Medical	29b. Signature and title of certifier	and manner stated.	mo	1		e number	124	29d	_	ed (Month, I	_	

State

31. Date filed (Month, Day, Year)



Registrar

20850

State of Maryland / Department of Health and Mental Hygiene 2 43235 Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Dav **Physician** Month Regina Susana Herrera December 28, 2008 10:00 a<sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year | If Under 24 Hrs. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 ☐ M 2 🔀 F 579-90-1960 Director 63 11, Aug. 1945 Peru Usual Residence of Decedent the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits or than "natural", or Items 23a or 28a-f show Directo 1 ☐ Yes 2 😿 No Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with ' I Hygiene. 14105 Parkvale Road 20853 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Black, White, etc 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 MXYes 2∐No SpecifyPeruvian 2 White Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) Caregiver Health Care permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked other any Injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rufino Torres Pastora Caballero ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Victor Herrera/Husband 14105 Parkvale Road, Rockville, MD 20853 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 St Burial 2 ☐ Cremation 3 ☐ Removal from State Jan. 3, Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2009 Silver Spring, Maryland 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 21. Signature of Furieral Service Licentee 500 University Blvd. W., Silver Spring MD 20001 enter the mode of dying, such as cardiac or respiratory arrest,

Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. Immediate Cause (Final **Physician** disease or condition resulting in death) Non-Small Cell Lung Cancer /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate caus. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed and Division of Vital Records, P.O. Box 68760, ↓ Due to (or as a consequence of): attending physician Physician/Medical If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 🗷 No Month Dav Year 4 Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 € Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 s has autopsy performed' certificate 1 ☐ Yes a No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 1 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D53177 December 28, 2008 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John Wallmark, MD 9707 Medical Center Drive, Rockville, MD 20878 31. Date filed (Month, Day, Year) 3. Registrar's Signature Registrar DEC 3 0

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 25 DEC 2008 4:00 LUCILLE I. HALL /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner PRINCE GEORGES 11406 Forest Lane Laurel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 □ M 2 🗗 F 88 Yrs Director Sept.28,1920 Maryland 213-16-2157 Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinat must be notified at 1 Tores 2 □ No Director MD Prince Georges Laurel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 72 hours after death with 20708 U.S.A. 11406 Forest Lane Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes ② No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: þ 3X Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within: Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nany injury or other traumatic event, the Mexical Industrian in the Mexical Industrian Ind Prince Georges Elementary/Secondary (0-12) College (1-4or 5+) Cook 12th Co. Schools 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Elizabeth Brown ပ John Thomas 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gwendolyn Morgan- Daughter PO Box 2681 Laurel, MD 20709 Saltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) National Mem 1/2/2009 Laurel, MD 22. Name and Address of FacilitySnowden Funeral Home, PA 21. Signature of preral Service License 246 N. Washington St Rockville, MD 20850 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Metastatic Breast Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ **X**o signed by the a P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ð icate has been sig page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐Mo 24a. Was an autopsy certificate 1 □Yes 2 🖂 o of Vital Physician: 25. Was case referred to medica examiner? director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 ∏ Yes 2 📉 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: Division Hospital or Attending 5 ☐ Pending investigation To the Hospital or Attention:

within 24 hours after death.

To the Funeral Director: Aft 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🖎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number December 28,2008 Q. Weltzmo D23743 ID two 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7525 Greenway Center Dr # 205 Greenbelt, MD 20770 Weltz, Martin 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar DEC 3 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** ANCE MERRILL HOPKINS 27 15:00 M 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Salisbury WICOMICO Peninsula Regional Medical Center If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 220-26-1926 7. Age (In yrs. last birthday) **Funeral** Hours 230-26-1926 Usual Residence of Decedent Months Days -28-1929 MD Director filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City. Town or Location r than "natural", or items 23a or 28a-f show 1 Yes 2 No Director SALISBURY 10f. Zip Code MD WICOMICO 10g. Citizen of What Country? 10e. Street and Number 21804 606 E. HINCOLN AVE USA Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Pages 1 and 2 should be filed within 72 mous and Pages 1 and Alental Hygiene.

ment of Health and Mental Hygiene. Maryland 21215-0036 1 ☐ Yes 2 ☐No Specify: WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) US POSTAL SERVICE BOSTAL CLERK 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evone. ALBERT RIAL HOPKINS COSETTE TUSLEY ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 606 ELincoln AVE SAUSBURY, MD 21804 PATRICIA HOPKINS (WIFE) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 WBurial 2 ☐ Cremation 3 ☐ Removal from State SAUSBURY, MD 1-2-09 4 ☐ Donation 5 ☐ Other (Specify) WICOMICS MEMORIAL ABOR 21. Signature of Funeral Service Licensee

22. Name and Address of Facility

23. Part for the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Immediate Cause (Final Myocardia Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine be executed physician and the burial-transil Due to (or as a consequence of): Box 68760 Physician/Medical The law requires that the death certificate attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) P.0. been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an autopsy performed?

1 Yes 2 No certificate ha To the Hospital or Attending Physician: 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this ( Certification: To 28a. Date of Injury (Month, Day, Year) After thi 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation Division 1 ☐ Yes 2 ☐ No death. filled in by the f 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide after within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

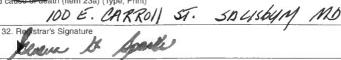
BY

State Registrar

31. Date filed (Month, Day, Year)

NFC 3 0 2008

30. Name and address of person who completed



of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

12-27-2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Howell 6.45 AM Wendell 12 24 08 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Salisbure At 5. Social Security Number Hospice the Lake Dicom If Under 1 Year | If Under 24 Hrs 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 6. Se **Funeral** Year) Min. Hours 1 M 2□F Months Days 168-32-937 2 Usual Residence of Decedent Director 1941 North Carolina Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or items 23a or 28a-f show Evaning must be notified at Workester Pocomoke 1 Yes 2 □ No Completed by Funeral Director Marykand 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States of america 1014 Cedar Street 21851 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ es 2 ☐ No 14 Race - American Indian. 11. Marital Status Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1961 - 65 Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced "natural", 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12th Officer Prison is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဂ 19a. Informant's Name/Relationship (Type. Print): 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pocomoke, Maryland 21851 Street Department of Health a Important: If item 27 is any Injury or other trains Joann 20c. Location - City or Town, State 20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Decem 26,2008 Salisbury 22 Name and Address of acility Anthony permit. E Ward Funeral of Funeral Service Licensee 21. Signature louch 30639 Hampden Princess Anne. ave 一个 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner te Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician; The law requires that the death certificate be executed ronar attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760 Physician/Medical 51 IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an was an autopsy performed?
Yes 2210 certificate Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Dother (Specify) HOSDICE 1 ☐ Yes 2 ☐ Yo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: / 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide after within 24 hours a

To the Funeral [ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 29c. License number ame of address of person who completed cause of death (Item 23a) (Type, Print) gmuelle 31. Date filed (Mor State 3 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Physician /Medica Examine

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Evariance must be notified at once.

Harvis, Maggie Baltimore, Maryland 21215-0036 Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Lirector After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760, State

•	1 - For State Registrar		,,,a,,	Cer	tificate of L	Death		Reg. N	20	08	4	323	9
	Decedent's Name (First, Middle, La	ast)					2. Date of D	eath			3.	Time of Deat	h
1 1	Macicis H	WVIS					Month	2	Day	ZOC	13 ·	9:37	PΜ
r	4a. Facility Name of not institution, gi	ve street and num	nber)		4b. City, Town, or	Location of Deat	th 1	4	4c. Count	ty of Deat	th		
	Coastal Hospi	ice at T	he bak	e	Salisk	only,	Md.		Wil	com	in		
		Sex 1 □ M 2 XF	7. Age (In yrs. I	ast birthday) _ Yrs.	Months Days	If Under 24 Hrs Hours Min	. (Month, I	Day, Yea		9. Birt	ountry)	(State or For	eign
-	152–44–9651 Usual Residence of Decedent		89	113.			Dec 2	3, 1	919		ΛŸ		
ı	10a. State 10b. County		10c. City	, Town or Loc	ation						10d. lr	side City Lin	nits
ector	MD Wicomie	co	He	bron							1	XYes 2□	No
	10e. Street and Number				10f. Zip Code			10g.	Citizen of	What Co	untry?		
ם מ	27043 S. Tourmal	ine Dr.			21830	)				US	Α		
	11. Marital Status	12. Was Dece	dent Ever in U.S	S. 13. W	as Decedent of H Yes, specify Cuba	ispanic Origin? (S	Specify Yes or N	lo-		ace - Ame		dian,	
L L	1 Never Married 2 Married	1 ∐Yes If Yes, Giv	2 X No		□Yes 2XNo	Specify:	,,			ify: Bl			
S D	3 XWidowed 4 ☐ Divorced	Year or Da		10 0 1				4.01					
ered	15. Decedent's E (Specify only highest gi	iducation rade completed)		(Give k	ent's Usual Occup ind of work done o O NOT use retired	luring most of wo	rking	166.	King of t	Business/	industry	,	
E	Elementary/Secondary (0-12)	College (1-	-4or 5+)		cial Work		strator		Stat	e Ga	verr	ment	
ٽ ھ	17. Father's Name (First, Middle, Las					18. Mother's Na		e, Maid	en Surna	me)			
0	James W. Kasey					Lena Jo	rdan						
	19a. Informant's Name/Relationship	(Type. Print)		19b. Mailing	g Address (Street	and Number or Fi	ural Route Num	ber, Cit	y or Tow	n, State, I	Zip Code	9)	
	Cheryl E. Byrd/d	aughter		27043	S. Tour	maline D	r., Heb	ron,	MD	2183	0		
	20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 〔	□ Removal from 9	C	emetery, crem	ition (Name of atory or other plac	e)	Date	20c.	Location	- City or	Town, S	State	
	4 □ Donation 5 □ Other (Spec		Cre	matory Delmar	oi va	12/	29/2008	ם [	elma	r, D	Æ		
	21. Signature of Funeral Service Lice	nsee		22. Le	Name and Addres	ss of Facility atson Fu	neral H	ome					
	Tavara 1000	TOO -		116	18 West 1	Rd., Sal	isbury,	MD	2180	1			
	23a. Par 1. Enter the disease, or cor shock, or heart failure. List only	nplications that ca y one cause on ea	aused the death ach line.	n. Do not ente	er the mode of dyin	, such as cardia	7			,	Inter	roximate val Between et and Death	
	Immediate Cause (Final disease or condition resulting in death)	_a. En	8 5	tage	Weghe	emers	Vem	en	tes		1	, RRZ	
	resulting in death)	Due to (	or as a consequ	uence of):	V						/		
_	Sequentially list conditions,	b	or as a consequ	bines (7)									
Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	2010 (	01 00 0 00110040										
Z	that initiated events resulting in death) Last	cDue to (	or as a consequ	uence of):									
edical		d											
<u></u>				_									
2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outo	come of pregna pirth 2 ☐ Fetal		Ectopic pregnance	v				ate of de	-		
sician	in the past 12 months? 1 ☐ Yes 2 <b>A</b> No		ant at time of d		Other (specify)				1	fonth	Day	Year	
5	9 Unknown	a a maturiba sating a dia sala	ath hut not room	ulting in the un	doduina sousa aire	on in Dort I	220 Dia	Ltobaco		ntributo t		use of death	
2	Part II. Other significant conditions	Contributing to de	Of the st	Thing in the uni	denying cause give	en III Part I.			2 No			4 Unkno	
Completed by	marines	71000	- win	THE STATE OF THE S					1				
ğ							24a. Wa	.s an opsy formed?		. Were au prior to death?	utopsy fi complet	ndings availa ion of cause	of
					<u>.</u>		1 □ Yes	2 🔼		1 ☐ Yes	2 🗷	No	
ne Re	25. Was case referred to medical examiner? 1 ☐ Yes 2 ∰ No	Hospital:		ED/0 1- "	Othe	or:	ath (Check only					(an - '	p (m)
<u> </u>	27. Manner of Death	28a. Date of	npatient 2  of Injury	28b. Time of	28c. Injur	4 L Nursing	Home 5 ☐ Re				cify)	espe	
	1 Matural 5 ☐ Pending 2 ☐ Accident investigation	(Mont	h, Day, Year)	Injury		ć? Yes 2 □ No			, ,				
<u>ဗ</u>	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	a   Zoe, Place	of Injury - At ho	me, farm, stre	et, factory, office		28f. Location	(Street	and Nun	ber or Ri	ural Rou	ite Number,	
Jer.	4 🗀 Hornicide	buildir	ng, etc. <i>(Specif</i> j	<b>/</b> /			City or T	own, St	ate)				
cai		Physician: To the											
Medical Certification:	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.												
	Acejano 1	2. 12et	les	har		9505	-	12	- 2	8	20	08	
1	Name and dress of person who	•	•		*			19 un -	-1.6	4.05		to	
	GREGORIO M. 31. Date filed (Month, Day, Year)	BELLO	SO, M.P.	5302 ture	CHINABE	RRY DR	. SALIS	RUR	(Y, N	10	218	501	
	(	J			All								

Registrar

DEC 3

2008

Sperke

			For State Registrar	State of Ma		ertificate of I		R	leg. No. 2008	43240
	Physicia	an	Decedent's Name (First, Middle, Last)     ELSIE	M. HAMMO	OND			2. Date of Dea Month	th Day 2008 Year	3. Time of Death 5:28 A M
3	/Medic Examin	- 0	4a. Facility Name (If not institution, give		) N D	4b. City, Town, or	Location of Death	TACORNAL .	4c. County of Death	3.20 11
*		٩	26685 Old State Ro				sfield		Somerset	
	Funeral Director		213 32 33.3	חוד מכוד	(In yrs. last birthda 4 Yrs.	Months Days	if Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day June 6,	Year) Cour	place (State or Foreign htry) land
	fand ow it		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location			1	0d. Inside City Limits
	Mary a-f sh	tor	Maryland Somerse	t	Cı	cisfield				1 ☐ Yes 2 No
	or 28	Director	10e. Street and Number	-		10f. Zip Code	17	1	I 0g. Citizen of What Cou	ntry?
	sath w		26685 Old State Ro	Dad 12. Was Decedent E	verin IIS 15	218 Nas Decedent of H		ecify Yes or No-		can Indian.
5-0036	be filed within 72 hours after death with the Maryland Hyglene. Hyglene do they than "natural", or items 23a or 28a-f show do ther than "natural", or items 23a or 28a-f show event, the M-dical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced	Armed Forces?  1 ☐ Yes 2 ☐ No if Yes, Give Year or Dates:	0	3. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ᠒No		Rican, etc.)	Black, White, Specify: Whi	etc.
ည် -	72 ho 'natur dical	Completed	15. Decedent's Edu (Specify only highest grad	cation le completed)	16a. Dec (Gi	edent's Usual Occup ve kind of work done DO NOT use retired	ation during most of work	ing	16b. Kind of Business/In	dustry
2	filed within Hygiene. Ither than "	duc	Elementary/Secondary (0-12)	College (1-4or 5+	)	Homemake			Own 1	Home
N Q	e filed Il Hygi other ent, t	Be Co	17. Father's Name (First, Middle, Last)			Пометельст		e (First, Middle,	Maiden Surname)	TOTTLE
ylar		10 E	Carl Fondelheit				Wilhelmi			
Maryland	S 0 0 0		19a. Informant's Name/Relationship (Ty			iling Address <i>(Street</i> 85 Old Sta			r, City or Town, State, Zip 白る。MD 218	0 Code) 317
	1 and Healt em 2 ther		Howard K. Hammond 20a. Method of Disposition	(nusband)		position (Name of rematory or other place		Date	20c. Location - City or To	
Baltimore,	0 0		1 ☑ Buna! 2 ☐ Cremation 3 ☐ F				1	o 2008	Crisfield, I	Maryland
a a	permit. Pag Department Important: I any injury o		21. Signature of Tune al Service Licens	-7	1	22. Name and Addre	ss of Facility			nar y rand
<u> </u>	8 3 E 8 8		Robert H. Bra	dshaw /Jr.		Bradshaw & 306 W. Mai	n St 0	Crisfiel	d, MD 2181	
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only o Immediate Cause (Final	ne cause on each line		/ /	/ 1		rest,	Approximate Interval Between Onset and Death
ž.	Physician /Medical		disease or condition resulting in death)	Due to (or as a	consequence of):	rdiavaic	elae e	vent	(191)	C d 7 kg
	Examiner		Sequentially list conditions	Care	very /	Juley D	lare			7 Juan
	ed sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):	0.10	centro	00		7
	ficate be executed physician and sthe burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a	consequence of)!	poer	Cours			· O Joseph
98760	ysicia ysicia ne buri	edical		d						
_	ertifica ing ph e as th		IF FEMALE:		,					
Box	The law requires that the death certificate be executed to has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physician/M	in the past 12 months?	23c. if yes, outcome p 1 □ Live birth = 2 4 □ Pregnant at t	2 ☐ Fetal death	BEctopic pregnancy	/		23d. Date of deliv Month	ery Day Year
o.	w requires that the di been signed by the should be detached	hysic	1 ☐ Yes 2 ☑ Ño 9 ☐ Unknown	9□Unknown						
S, P	es that gned b	by P	Part II. Other significant conditions co	ntributing to death bu	t not resulting in the	underlying cause giv	en in Part I.		bacco use contribute to t	
ord	requir een si nould b		Dy Gly den	ria				1 U Y	es 2.12€No 3. □ Prol	bably 4 □Unknown
Vital Records,	has b	Completed	- Hyporkenso	à-	·			24a. Was a autop perfor	sy prior to co	opsy findings available impletion of cause of
ē			25. Was case referred to medical			_	26. Place of Deat	1□ Yes	2 No 1 ☐ Yes	2 No
	ysicia is cert direct	To Be	examiner?	Hospital: 1 ☐ Inpatier	nt 2 ER/Outpat	ient 3 DOA Oth	or:		lence 6 □Other (Speci	fy)
Division or	iding Phys th. : After this funeral dir		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injur (Month, Day		y Wor		28d. Describe h	ow injury occurred	
20	r Attendi er death. rector: A by the ft	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e Place of inju	ny - At home farm	M 1 ☐ street, factory, office	Yes 2 □No	28f Location /S	Street and Number or Run	al Pouto Number
2	or Atten after death Director:	Certification:	4 ☐ Homicide determined	building, etc	(Specify)	street, lactory, office		City or Tow	n, State)	ai noute Number,
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific; completely filled in by the funeral director,	edical C			examination and/or				cause(s) and manner as s date and place, and due t	
	o the	Med	29b. Signature and title of certifier	and mariner sta		29c. Licens	se number		29d. Date signed (Month,	Day, Year)
	01.		· LIQUE			1200 C	326.	4	12/24/0	Loop
	25		30. Name and address of person who c	ompleted cause of de	ath (Item 23a) (Typ	9 Print)	< 1	100	Pro 1	no 16
	<u>ک</u> Sta	te	31. Date filed (Month, Day, Year)	32. Registra	r's Signature	Threat	1 Ducke	105	Chuld	1018
	Registi		DEC 292	008 Am	r's Signature	par				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State RegistrarAMEND#10bperFH12/30/08,EMV,McCo Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** A M 2008 YNETIE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore University of Marying 5. Social Security Number 6. Sex Medical Center 9. Birthplace (State or Foreign Date of Birth Age (In yrs. last birthday) Funeral 08706760 (ear) Months Days Hours 1 □ M 2 💢 F 215-80-2615 Washington, DC 48 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show MD Montgomery Cnty Silver Spring ir than "natural", or items 23a or 28a-f sh the Medical Extrainer must be notified 14 Yes 2 □ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1009 Cresthaven Drive 20903 USA permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a any lightry or other traumatic event, Ite Modical Examine crimes 100ce. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 1 □Yes 2 No If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Billing Specialist Hospital 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Dorsey Elsie Henderson ည 19a. Informant's Name/Relationship (Type. Print)
Terrence Jacobs/Spouse 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1009 Cresthaven Dr., Silver Spring, MD 20903 20b. Place of Disposition (Name of cemetery, crematory or other place)

Chesapeake Crematory 12/29/08 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McGuire Funeral Service 7400 Georgia Ave., NW Washington, DC 20012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Hemour lmonary /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be execute Lym sician and burial-trans Due to (or as a consequence of): physician a Division of Vital Records, P.O. Box 68760 Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Year Day Pregnant at time of death 5 ☐ Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 🙀 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No t □Yes 2 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation te Funeral Director; Af bletely filled in by the fun 1 □Yes 2 □ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar 31. Date filed (Month, Day, Year)

DEC

0

DHMH 17 Rev 1/2001

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Le816

Baltimore mo

State of Maryland / Department of Health and Mental Hygiens, 1 - For State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) DECEMBER Day 25, 2008 **Physician** 7:34PM **JAMES** ANTHONY JONES /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 5305 HALIBUT PLACE WALDORF CHARLES | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | SEPT • 23 5. Social Security Number 241-82-4169 9. Birthplace (State or Foreign 6 Sex 7. Age (In yrs. last birthday) **Funeral** CAROLINA 58 Yrs. 23,1950 Director Usual Residence of Decedent with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits r then "natural", or Iteme 23a or 28e-f ehow the Madical Expander must be notified at MD CHARLES WALDORF 1 Yes XXNo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5305 HALIBUT PLACE 20603 UNITED STATES Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No If Yes Give 14. Race - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes ② No Specify: Specify: BLACK þ 3 ☐ Widowed 4 ∑ ivorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) INSURANCE ADJUSTER permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygien important: if item 27 ie marked other It any injury or other traumatic event. Its once. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be JULIA CARNEY JAMES AARON JONES JONES ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code  $2228~{\tt Glaston~Lane}$ , Charlotte, NC 28219a. Informant's Name/Relationship (Type, Print) 28262 DEXTER R. JONES / BROTHER 20b. Place of Disposition (Name of cemetery, crematory or other place) DEC. Date 31, 20a. Method of Disposition 20c. Location - City or Town, State X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) TARBORO, N.C. EASTLAWN CEMETERY 2008 TERRENCE L. JOHNSON FUNERAL SERVICE, PA JOHNSON#m00993 4433WHITE PLAINS LN., WHITE PLAINS, MD TERRENCE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Schenic Physician beaut /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immodrate cause. Enter Underlying Cause (Disease or injury that initiated events Dira to (or as a consequence of) Examiner led by the attending physicien and detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Box 68760. by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) of Vital Records, P.O. 9 Unknown 9 Unknown signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ate has been sign page 2 should be 3 Probably 4 Unknown 1 ☐ Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 No certificate 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home Residence 6 Other (Specify) 2 Yes 2 No 3□ DOA s efter de... rai Director: After ... - by the funeral dr this 27. Manner of Death 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred Division 10 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours e 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D00550883 Dec 21. 2008 30. Name and andress of person who completed cause of death (Item 23a) (Type, Print) 11655 W. Ne SUR adria pol La plata M. Tagaren 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registra

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician 8:45 P M NGOL KOSYLA DEC. 23. 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner MONTGOMERY ALTHEA WOODLAND NURSING HOME SILVER SPRING If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 ☐ M 2 🖫 F Director 203-60-8709 101 JAN. 1907 LAOS Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1X Yes 2 □ No Director MD. PRINCE GEORGES LAUREL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or 1025 TURNEY AVE. 20707 LAOS Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☑ No
If Yes, Give
Year or Dates: Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 21 No Specify Specify: Completed by 3 ☑ Widowed 4 ☐ Divorced ASIAN 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 8 HOMEMAKER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Heuang Kosyla Feau Kosyla ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a tem 27 is CHESTER KOSILA/SON 1025 TURNEY AVE., LAUREL, MD. 20707 permit. Pages 1 and Department of Healt Important: If item 2: any injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHAMBERS CREMATORY Jan. 3, 2009 RIVERDALE, MD. 21. Signature of Funeral Service Licersee 22. Name and Address of Facility
CHAMBERS FUNERAL HOME & CREMATORIUM, P.A. M00091 5801 CLEVELAND AVE., RIVERDALE, MD. -11 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ASPIRATION PNEUMONIA 2 WEEKS /Medical Due to (or as a consequence of): Examiner ALZHEIMERS DISEASE 15 YRS. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 X No Month Day Year Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2X No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 🕅 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) Hospital: 1 ☐ Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 X Natural 5 Pending within 24 hours after deau..

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and 29c. License number D21900 DEC. 24, 2008

DHMH 17 Rev 1/2001

State Registrar

7610 CARROLL AVE. #280, TAKOMA PARK, MD. 20912

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

M.D.

SMITH S. HO,

DEC 3 0 2008

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** Robert N. Kessler, Sr. 25. 2008 3:20 a December /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Brooke Grove Nursing Home Sandy Spring If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year April 21, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year) Days 1**X** M 2 □ F 1921 Pennsylvania 87 178-16-5958 Director Usual Residence of Decedent 10c, City, Town or Location 10d. Inside City Limits 10a. State ortant; if item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the incident Evanture must be notified at 1 ☐ Yes 2 1 No Director Maryland Montgomery Olney 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 17405 Cherokee Lane 20832 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 72 hours after 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White ≥ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Canteen Vending Co. Bookkeeper 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental Harvey M. Kessler Sally Newcomer ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s Health s 17405 Cherokee Lane, Olney, Maryland 20832 Robert N. Kessler, Jr./Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 ₩₩Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important; If i Gate of Heaven Cemetery Dec 31, 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, Maryland 21. Signatur of Fureral Service 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.  $\nabla$ 0 500 University Blvd. W., Silver Spring, MD 20901 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ASPIRATION **Physician** PHELLMONIA 6 HOURS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine requires that the death certificate be executed and burial-tran Due to (or as a consequence of) physician Physician/Medical the as attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy þ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) Pregnant at time of death signed by the a P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown GASTRO ENTERITIS page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate 1 □Yes 2 🗷 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. WILLIAMS PORT ST. APTIZAN HOWE E. 31. Date filed (Month, Day, Year) egistrar's Signature State Registrar

		4	For State Registrar	State	of Maryla	nd / Depa <i>Ce</i>	artment o <i>rtificate d</i>			Mental H	ygier Reg. 1	ne No. 2 (	800	432	45
		_	1. Decedent's Name (First, Middle, Las	st)						2. Date of D		Day	Year	3. Time of Dea	ath
Phys /Me	icia: dica		Alice Masako K	awamur	a					Decem			2008	7:30	Ma
Exar			4a. Facility Name (If not institution, giv	e street and n	number)		4b. City, Tow	n, or Locati	ion of Death		4	4c. County	of Death		_
**			19310 Club House		I		Montgo	omery	Villa nder 24 Hrs.	age 8. Date of E	1141	Mon	tgom		
Funer			5. Social Security Number 6. S 561–16–4824	ex □M2 <b>∑</b> F	7. Age (In yr 85	rs. last birthday) Yrs.	Months Da			Month, I	Day, Yea	1923	9. Birtin	place <i>(State or Fo</i> intry) <b>ifornia</b>	əreign
Direct		+	Usual Residence of Decedent							rug. 2	· , .	1,72,5	car	TTOTITE	
yland	0.		10a. State 10b. County		10c. 0	City, Town or Lo	cation							10d. Inside City L	imits
a-fsh	,	50	Maryland Montgo	mery		Monto	omery '	Villa	ge					1 ☐ Yes 2 [	XNo
or 28		Director	10e. Street and Number				10f. Zip Cod		06			Citizen of	What Cou	ntry?	
ath wi	:	<u>e</u>	19310 Club House					208				SA			
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ire INC dice Incomplete.	Π.	Funeral	11. Marital Status	Armed I	cedent Ever in Forces? 2 12 No	U.S. 13.	Was Decedent If Yes, specify (	of Hispanic Cuban, Mex	c Origin? (Sp xican, Puerto	pecify Yes or No Rican, etc.)	10-		ce - Amer ck, White,	ican Indian, etc.	
rs aft	l l'	ò	1   Never Married 2   Married  Widowed 4   Divorced	If Yes, O	Give		1∐Yes 2🙀	No Spe	ecify:			Specif	y:	Asian	
2 hou			15. Decedent's Ed	ducation ,		16a. Dece	dent's Usual O	ccupation		lain -	16b.	Kind of B	usiness/Ir	ndustry	
e. an "n	-	Completed	(Specify only highest gra		(1-4or 5+)	- (Give	kind of work do DO NOT use re	ne during i tired)	most of work	King					
ed with		5	12			Admi	inistra							vernment	
be file d oth even	0	g	17. Father's Name (First, Middle, Last)	)						ne (First, Midd	le, Maid	en Surnan	ne)		
y ould out Mer arke	ı	<u> </u>	Ricki Kawamura			T			eru Ur						
12 st th and 7 is n traur			19a. Informant's Name/Relationship (				ng Address (St								
1 and 1 and Healt em 2		-	Ricky T. Takai/Ne 20a. Method of Disposition	phew	20b	Place of Dispo	sition (Name o	f		Montgo Date				, MD 208 own, State	86
ages ent of t: If it			1 ☐ Burial 2 🖾 Cremation 3 🗆		m State Me	cemetery, cree tropoli	natory or other		r'y De	20. 28,		1	32-	TTd as and as	• _
nit. P artme ortan injur	di	-	4 ☐ Donation 5 ☐ Other (Specification 21. Signature of Funeral Service Licer			2:	Name and A	dress of Fa	acility	2008				, Virgin	ıa
Dep Dep any	ouce.		Alelent 1	14-	1	F	rancis	J. Co	ollins	Funer	al E	Home	Inc.	ng,MD 20	901
		1	23a. Part 1. Enter the disease, or com	plications that	t caused the de							LVCI	DDI I	Approximate Interval Betwee	
Physicia	ın		shock, or heart fallure. List only Immediate Cause (Final		rdiac A	rrest								Onset and Dear	th
/Medic	al		disease or condition resulting in death)	и	o (or as a conse										
Examin			Conventiolly list conditions	b At	herosc1	lerotic	Cardio	ascu:	lar Di	sease				10 year	s
, p #		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to	o (or as a conse	equence of):									
ecute and trans		Eal	Cause (Disease or injury that initiated events resulting in death) Last	c											
icate be executed physician and the burial-transit	L		Todaking in dodkin, Eddi	Due	o (or as a conse	equence on:									
ficate phys	-	dical		d											
To the Hospital or Attending Physician: The law requires that the death certifusing 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	1		IF FEMALE: 23b. Was decedent pregnant		outcome of preg							23d. Da	ate of deliv	/erv	
leath attel	1	Pnysician/M	in the past 12 months? 1 ☐ Yes 2 ☑ No		e birth 2□Fe egnant at time o		☐ Ectopic pregr ☐ Other (specif						onth	Day Year	.r
by the		NSI	9 Unknown	9 🗆 Un	known										
s thai gned l e det	1	by P	Part II. Other significant conditions of	contributing to	death but not re	esulting in the u	nderlying cause	given in P	Part I.	23e. Dio	tobacc	o use con	tribute to	the cause of death	h?
equire en siç ould b	-		Atherosclerotic C	erebro	vascula	r Disea	se, A	dult-(	Onset	1 🗆	Yes	2 ⊈No	3□ Pro	bably 4 🗌 Unkr	nown
law re as be 2 sho	-	Completed	Diabetes, Hyperte	nsion						24a. Wa	s an opsy	24b.	Were aut	opsy findings avai	ilable
The ate h		Ę	, 31							per 1 □Yes	formed:	?	death?		0 01
ctor,		g	25. Was case referred to medical examiner?					26. P	Place of Dea	th (Check only					
hysic this o		<u> </u>	1 Yes 2X No			☐ ER/Outpatie			☐ Nursing H	ome 5 <b>⊡∜</b> Re	sidence	6 □ Otl	her <i>(Spe</i> c	ify)	
ing P		<u>.</u>	27. Manner of Death 1   ■ Natural 5 Pending	(Mo	te of Injury o <i>nth, Day, Year)</i>	28b. Time o Injury		Injury at Work?		28d. Describ	e how in	njury occur	red		
ttend death stor:		cat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		as of Injury At	home form et		1 ☐ Yes 2	2 🗆 NO	29f Location	/C++	and Mirani	6 C	- 1 Causta Abumban	
or A after Direc		Certification:	4 ☐ Homicide determined	buil	lding, etc. (Spe	home, farm, str ecify)	eet, lactory, offi	Ce		City or T	own, St	ate)	ber or Hui	al Route Number,	,
spital ours neral			29a. Certifier	nysician: To t	he best of my k	nowledge, deat	h occurred at tl	ne time, dat	te and place	e, and due to th	ne cause	e(s) and m	nanner as	stated.	
e Ho 24 h e Fur	-	Medical	(Check only 2 Medical Examone)		basis of exami anner stated.	ination and/or in	vestigation, in	my opinion,	, death occu	rred at the tim	e, date a	and place,	and due	to the cause(s)	
To th To th COMP	:	Z E	29b. Signature and title of certifier					cense numb			29d. I	Date signe	ed (Month	, Day, Year)	
10			Dandra Ta	kai M	0		D	255	4.3		1	2-28	3-20	08	
7		-	30. Name and address of person who												
			Sandra Takai, MD			nantown		‡200 <b>,</b>	Germa	antown,	MD	2087	4		
	State		31. Date filed (Month, Day, Year)  DEC 3 0 200	32	Registrar's Sig	nature	all I								
Regi			DEE 3 11 711	10 430	2 6268 B	V SHOW	The state of the s								

State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician December 30, 2008 4:15 a Henry Klotz /Medical Arthur 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Calvert 13325 Dowell Road <u>Solomons</u> If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1**K**] M 2□ F 95 Dec. 21, 1913 Director Missouri 216-44-4352 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location r 28a-f show notified at 10a. State 10b. County 1 ☐ Yes 2 ☐ No Director Maryland Calvert Solomons 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number "natural", or Items 23a or death with 13325 Dowell Road 20688 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) C P A Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be K1otz Ruth Herman Harkins 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Department of Health a Important: If item 27 Is any injury or other trains 40829 Magee Drive, Leonardtown, Maryland 20650 Thomas C. Klotz / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield-Echols Cre01/02/2009 | Charlotte Hall, MD. 21. Signature of Funeral Service Licens

Danielle Ward 101403 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, MD 20650 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Alzhie mers **Physician** Y-ces 5 /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the attending pl 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) ed by the 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an performed? Yes 2 Mo certificate To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, pa 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5X Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Accident (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 12/31/08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 24035 Three Notch Road, Hollywood, MD David M. Federle, M.D. 31. Date filed (Month Day Year) 2009 State

Registrar
DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** BARBARA ELOISE LAWSON December 3:05 P M 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) Examiner KLINE HOSPICE HOUSE Mt. Airy Frederick If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Months Days 1 □ M 2 X F Hours 216-38-6132 73 1935 Maryland Nov. Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits r 28a-f show notified at Jefferson Ranson 1 XYes 2 No W. VA. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with to nent of Health and Mental Hygiene.

Int: If item 27 is marked other than "natural", or items 23a or 2 inty or other traumatic event, the Medical Examiner must be not so other traumatic event, the Medical Examiner must be not not other traumatic event. United States 25438 83 Woodland Court 44A Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Specify: White Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify 3 ₩ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Assembler Plastic Company 10 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Florence Park John Roberts ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21756 Ethel F. Lucas / Daughter P. O. Box 126, Keedysville, Md.Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Department o Important: If any injury or Parklawn Mem. Park 12/31/08 Rockville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Muriel H. Barber Funeral Home 8/. muriel Barke P. O. Box 5038, Laytonsville, Md. 20882 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Extensive Small Cell of Lung 3 Months /Medical Due to (or as a consequence of): Examiner 5 Years COPD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner death certificate be executed burial-tran Due to (or as a consequence of): Box 68760. physician the attending p as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death 5 Other (specify) ned by the a Division or Vital Records, P.O. 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by sign 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy perform 2 X No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Hospice Other: 4 Nursing Home 5 Residence 6 Cother (Specify) 1 ☐ Yes 2 No Certification: To this ours after death.

neral Director: After this filled in by the funeral d 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 X Natural 5 ☐ Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) December 29, 2008 D 14626 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) P. Gregory Rausch, M.D. 501 W. Seventh St., Ste. 1A, Frederick, Md. 21701 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar DEC 3 0 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amended item #13 & 16b per f.homeState of Maryland / Department of Health and Mental Hygiene

12/20/08 F.T. Certificate of Death world

Reg. No. 2008 For State 1 tem 25 Registrar pysician, 12/30/08, E.T, Certificate of Death world 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 26, 2008 **Physician** 10:30AM December Anne A. McCourt Lewis /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Wicomico Salisbury Rehab and Nsg Ctr. Salisbury 7. Age (In yrs. last birthday) 80 Yrs. If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 8. Date of Birth (Month, Day, Pep. 17, 5. Social Security Number **Funeral** Days Hours 1 ☐ M 2 🛛 F Florida 1928 **Director** 159-22-9639 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State if item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Berlin MD Worcester 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21811 5 The Pointe Funeral 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. ould be filed within 72 hours after of Mental Hygiene. arked other than "natural", or iter 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Education University of DE Elementary/Secondary (0-12) College (1-4or 5+) professor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be 1 Department of Health and Mental I Important: If Item 27 is marked of any injury or other traumatic eve-once. Edna Schwierk William Allardice ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 The Pointe Berlin, MD 21811 Kenneth Lewis-husband 20b. Place of Disposition (Name of competery, remajory or other place)

Cape Hene Lope Crem. Dec. 29, 08 Frankford, DE 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Burbage funeral home 21. Signature of Funeral Septice Licensee 108 Williams street Berlin, MD 21811 1400 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician edidisease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner death certificate be executed use as the burial-tran Due to (or as a consequence of) or Vital Records, P.O. Box 68760, attending physician IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 certificate 2 No or Attending Physician: 25. Was case referred to medical examiner? 26 Place of Death (Check only one Be 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this After thi funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation Division 1 Natural Injury 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 🚅 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SALISBURY DR. WILLIAM ROBINS 200 CIVIC AVE 21804 MD 31. Date filed (Month, Day, Year)

DEC 3 0 32. Registrar's Signature State 2008

DHMH 17 Rev 1/2001

Registrar

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Richard Layfield Lee 2008 Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death 1: comico Hospico at + If Under 24 Hr 8. Date of Birth (Month, Day, Year) If Under 1 Year Age (In yrs. last birthday, Birthplace (State or Foreign Country) Days 218-20-9353 1 X M 2 □ F Yrs. 79 06/23/1929 Maryland Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits 1 Ves 2 □ No Maryland Worcester Berlin 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number 21811 USA 11647 Beauchamp Rd., Unit 119 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: Army Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 X Married 1 ☐Yes 2**X** No Specify: Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) life insurance 12 agent 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) James Preston Layfield Arinda Marie Beard 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11647 Beauchamp Rd., Unit 119, Berlin, MD 21811 Norma Lee Layfield/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Salisbury Crematory 12/30/08 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens Name and Address of Facility
Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death arteriosel Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 ☐No 9 Unknown 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tyes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an autopsy performed? 1 □Yes 22 No ronce 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐Yes 2 ☐ No 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Examiner law requires that the death certificate be executed and P.O. Box 68760, attending physician ed by the detached Division of Vital Records, has Hospital or Attending Physician: The this To the Hospital or Attena within 24 hours after death To the Funeral Director; mpletely filled in by the

**Physician** 

/Medical

Examiner

Director

Funeral

ģ

Completed

Be

ဂ

Examiner

Physician/Medical

≥

Completed

Be (

Certification; To

Medical

29a. Certifier

**Funeral** 

Director

ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Mortical Examiner must be notified at

ene. than "

permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If item 27 is marked other t

Physician

/Medical

death with the Maryland

filed within 72 hours after

Maryland

Baltimore,

icharc

State Registrar

29b. Signature and title of certifier

and manner stated.

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) 12-27-2008

Name and address of person who completed cause of death (Item 23a) (Type, Print)

BELLOSO, M.D.; 5302 CHINABERRY DR., SALISBURY, MD 21801 GREGORIO M. 31. Date filed (Month, Day, Year)

DEC 3 0 2008

			For State Registrar	State of M	aryland /		tment of H	leaith and N Death		giene 00	8	43250
•			Decedent's Name (First, Middle,	Last)		-			2. Date of De	ath		3. Time of Death
	Physici /Medic		NORVAL	WILLIAM	LECAT	ES,	SR.		Month 2	2 7 E	8°C	6:14 A M
	Examir		4a. Fecility Name (If not institution,	give street and number)	0 10	Vo	4b. City, Town, or	Location of Death		4c. County of		nico
-	Funeral				ge (In yrs. last bi		If Under 1 Year Months Days	If Under 24 Hrs	8. Date of Birt			lece (Stete or Foreign
	Director		221-18-2751 Usual Residence of Decedent	1 <b>X</b> M 2□F	81	Yrs.	Months Days	A	PRIL 2	3,1927	MAR	YLAND
5	show		10a. State 10b. County		10c. City, Tov		tion				10	0d. Inside City Limits
>	the Man 28a-f sh notified	ctor	DELAWARE SUSS	3EX	DEL	MAR						1 ☐ Yes 2 ☐ XNo
Norva	€ 9 €	Funeral Director	10e. Street and Number 16092 WHITES	SVILLE RO	AD		10f. Zip Code 1994	0		10g. Citizen of Wh		try?
S	ems 2	ınera	11. Marital Status	12. Was Decedent Armed Forces?		13. Wa	as Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No Rican, etc.)	- 14. Race - Black	- America White, e	
36	"natural" or Items 23a	by F.	1 ☐ Never Married 2 ☑ Marrie 3 ☐ Widowed 4 ☐ Divorced	lf Yes 2√1 If Yes, Give Year or Dates:	No	10	]Yes 2 DXNo	Specify:		Specify:		
Le cote	72 hounanatura	ted	15. Decedent's (Specify only highest	Education	16a	Deceder	nt's Usual Occup	ation during most of work	king	16b. Kind of Busi	iness/ind	lustry
212	within 7 ene. then "r	Completed	Elementary/Secondary (0-12)	College (1-4or	5+) TI	life. DC	DRIVE	1)	(ing	POULTR	v	
	filed v Hygie other t	CO	8 17. Father's Name (First, Middle, L.	ast)			DICEVE		e (First, Middle,	Maiden Sumame)		
Maryland	ges 1 and 2 should be filed within to fleath and Mental Hygiene. It of Health and Mental Hygiene. It item 27 is marked other than or other traumatic event, the Mental traumatic event, the Mental Hygiene.	To Be	GRANVILLE	LECATES				MARY	TRUIT	Г		
Aan	2 should n and Mer Is marke raumatic		19a. Informant's Name/Relationshi							ar, City or Town, St		
	item 27 I		ANNIE B. LECA  20a. Method of Disposition	MIES WI	20b. Place of	of Disposit	ion (Name of		Date	20c. Location - Ci		
ē	Pages nent of I int: If it		1 X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 1 Other (Spe				TED		30/08			E, DELAWAR
Baltimore.	permit. Pages Department of P Important: If ite any injury or of page.		21. Signature a pontral Service Li		METHO	2W	T CHUR ATSON	FATES FI	UNERAL	HOME, I	NC.	
	898 59	4	1 DEG	W. Ya	W J					SEAFOR	D, 1	DE. 19973
		- 4	23a. Pert T. Enter the disease, stock, or heart failure. Vist o	omplications that caused nly one cause on each li	d the death. Do ine.	not enter	the mode of dyin	g, such as cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a.Cnoc S	tage +	rum	ary Co	ardiony	opath	4		- years
	Examiner		Sequentially list conditions,	b					V			
	ed sit	Examiner	if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequence	of):						
_	execut n and al-trar	Exan	that initiated events resulting in death) Last	c. Due to (or as	a consequence	of):					-	
8760.	cate be executed physician and the burial-transit	dical					de carego					
89	ertifica ling ph e as th	Med	IF FEMALE:							12		
Box 6	that the death certifi ed by the attending I detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome  1 Live birth  4 Pregnant at	2 Fetal death		ctopic pregnancy other (specify)			23d. Date of Month		ry Day Year
O.	it the d by the tached	hysic	1 Yes 2 No 9 Unknown	9□ Unknown		70,0	Miler (Specify)					
Division of Vital Records, P.O.	Attending Physicien: The law requires that the death certific death.  death.  ector: After this certificate has been signed by the attending p by the funeral director, page 2 should be detached for use as	by P	Part II. Other significant condition	s contributing to death b	out not resulting	in the und	erlying cause givi	en in Part I.		bacco use contribu		
ord	requir	eted	Progressive	Vemen	tia				1 D Y	es 2. No 3	Proba	ably 4 Unknown
Rec	nelaw shast ge 2 s	Completed by	Chronic Re	nal Di	weap	<u>ٽ</u>			24a. Was autop	sy pric	or to com ath?	sy findings available apletion of cause of
tal	ician: Th certificate rector, pag	Be Co	25. Was case referred to medical	1				26. Place of Deat		2 <b>⊠</b> No 1 □		2₩ No
<u>&gt;</u>	Physici this cer al direc	To B	examiner? 1 ☐ Yes 2X No		ent 2 ER/O	utpatient	3□ DOA Oth			lence 6 Other	(Specify	Hospice
o uc	ding P. h. After t		27. Manner of Death 1. ■ Natural 5 □ Pending		ury 28b.	Time of Injury	28c. Injun Work	yat k? Yes 2 □ No	28d. Describe h	ow injury occurred	1	
/isic	Attendi r death. ector: A by the fu	Certification:	2 Accident investiga 3 Suicide 6 Could no	ot be 28e. Place of Inj	jury - At home, fa	arm, stree		195 2 100	28f. Location (S	Street and Number	or Rural	Route Number,
ij	s after af Dire	Certi	4 - Homicide determin	building, et	tc. (Specify)				City or Tow	m, State)		
	Hospital 24 hours a Funeral I tely filled	edical	(Check only 2 Medical E:	Physician: To the best xaminer: On the basis o	of examination ar	e, death o	ccurred at the tim stigation, in my of	ne, date and place, pinion, death occur	and due to the cred at the time, or	cause(s) and mann date and place, and	er as sta	ated. the cause(s)
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has comilletely filled in by the funeral director, page 2	Med	one) 29b. Signature and title of certifier	and manner st	ated.		29c. License			29d. Date signed (/		
	V = 1		1 Sugario	m Roll	950 2	1	D 29	9505		12-27		
	JAN.		30. Name and address of person w	ho completed cause of d	death (Item 23a)	(Type, Pr				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		Live
			31. Date filed (Month, Day, Year)	BELLOSO	rar's Signature	530	2 CHILM	ABERRY	DR. 5/	LISBURY	MD	21801
	Sta Registr		TEC 3 1	2008 2008		· A	sele			•		

		For State Registrar			T Maryla			rtment of F				Reg. No		18	43251	
Physicia		Decedent's Name	(First, Middle, La JAME		MOOR	F					2. Date of Do Month DEC •	Da 23	200	ear 8	3. Time of Death	
/Medic Examin		4a. Facility Name (If				تا.		4b. City, Town, o	r Locatio	on of Death	DEC.		. County of		10.47 1	
<u> </u>			L REGION					LA If Under 1 Year	URE	L der 24 Hrs.	8. Date of B		RINCE			
Funeral Director		5. Social Security Nu 220-10-48 Usual Residence of	896	sex 1		Months Days Hours Min. (Month, L						orth Jay, Year)  9. Birthplace (State or Foreign Country)  31,1919  MARYLAND				
yland at		10a. State	10b. County		10c.	City, Town	or Loc	ation		***			- "	10	Od. Inside City Limits	
e Mar Ba-f sl	Director	MD.	PRINCE	GEORGES				LAUREL				1 X Yes 2 No				
with th		10e. Street and Num		v Dī				10f. Zip Code	20708	0		10g. Citizen of What Country?  U.S.A.				
death ms 23	Funeral	1 Z Z U U 11. Marital Status	BRITTAN	12. Was Dece	12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specifices, specify Cuban, Mexican, Puerto Richards)						ecify Yes or N	0-	an Indian,			
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Inmoortant: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the intentional Examinar must be notified at once.	by	1 ☐ Never Marrie	ed 2□ Married 4 ☑ Divorced	Armed Fo 1 ∰Yes If Yes, Gi Year or D	ve 19	40- 946		Yes, specify Cuba	Spec		Hican, etc.)		Specify:	White, e		
72 hc "natul	letec	(Speci	15. Decedent's E ify only highest gr			Give I	ent's Usual Occup	during n	nost of work	ing	16b. K	ind of Busin	ness/Ind	lustry		
within iene. than	Completed	Elementary/Secon	ndary (0-12)	College (	1-4or 5+)	ille. L	O NOT use retired MACHINI	MACHINIST					NAV	<b>Y</b> Y		
e filed al Hyg other	Be C	17. Father's Name (First, Middle, Last)							other's Name	e, Maider			UNK.			
ould b Ment arked atlc e	70 E		JAMES	W.	MOORE											
d 2 sh thand thand 7 Ism traum		19a. Informant's Na	. MOORE/					g Address (Street								
s 1 and if Heal		20a. Method of Disp	oosition										29928 City or Town, State			
iit. Pages artment o ortant: If njury or		20a. Method of Disposition  1 Burial 2 M Cremation 3 Removal from State  4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  CHAMBERS CREMATORY 12-30-2008 RIVERDALE, MD.												MD.		
Depa Impo any i		21. Signature of Full		ambu	16D	м0009		HAMBERS 801 CLEV	FUNE	RAL H	OME &	CREM.	ATORII	UM, P	O737	
W			rt failure. List only	nplications that of one cause on e	caused the d										Approximate Interval Between Onset and Death	
Physician /Medical		Immediate Cause ( disease or condition resulting in death)	Final n	a	ONIC O			VE LUNG	DISI	EASE				-		
Examiner		Sequentially list con	aditions		HYSEMA											
red isit	niner	Sequentially list con if any, leading to im- cause. Enter Under Cause (Disease or i that initiated events	mediate rlying		(or as a cons		f):									
execu in and ial-trar	Examiner	that initiated events resulting in death) L	replaces of in fluid little devents and in death) Last c. LUNG CANCER  Due to (or as a consequence of):													
ificate be executed g physician and as the burial-transit	edical		•	d										$\perp$		
sertific ding p		IF FEMALE:		23c If yes ou	tcome of pre	onanov										
Attending Physician: The law requires that the death certificate actor. After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use as	Physician/M	23b. Was decedent in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?	he?   I Live birth 2 Fetal death 3 Ector					Ectopic pregnancy Other (specify)					23d. Date of delivery Month Day		
w requires that the de been signed by the should be detached	by Pr									23e. Did	tobacco	use contrib	ute to th	e cause of death?		
equire sen sig ould b											1	Yes 2	No 3	☐ Prob	ably 4 Unknown	
e law r has b	Completed										24a. Wa	s an opsy formed?	pri	ere autop or to cor ath?	osy findings available inpletion of cause of	
in: The ificate h		25. Was case referr	red to medical	1					oe Di	and of Door	1 □ Yes	2 X No			2 No	
ysicla is cert directo	To Be	examiner?		Hospital:	Inpatient 2	ER/Out	patien	t 3 DOA Oth	or:		h <i>(Check only</i> ome 5 ☐ Res		6 ☐ Other	(Specifi	/)	
ng Ph fter th ineral	on: T	27. Manner of Death	n 5 ☐ Pending	28a. Date (Mor	of Injury oth, Day, Year	28b. T	ime of jury	28c. Inju			28d. Describe				,	
ttendi Jeath. tor: A the fu	icati	2 ☐ Accident	investigation 6 □ Could not I		of Injury A	t home far	m etre	M 1 □ eet, factory, office	Yes 2	-	29f Location	(Street a	nd Mumbas	o = D	I Route Number,	
ital or A	Certification:	4 Homicide	determined	build	ing, etc. (Sp	ecity)					City or To	wn, Stat	e)			
Second Part   Second Part																
29b. Signature and title of continer  29c. License number  29d. Date signed (Month, D																
		80. Name and addr	ess of person who	completed cau	oo of doalh?	tem 23a) (	Type, I		040/	4			DEC.	-4,	2000	
		SHAI		ANI, M.I			LIT	TLE PATU	XEN7	PARK	WAY #2	00,	COLUM	BIA,	MD.21044	
Sta Registr		31. Date filed (Mont		No.	Registrar's Si	4 24	A -	e a								
HMH 17 Pay 1/2	_	DEC	3 0 200		15. 1 A	1º A										

State of Maryland / Department of Health and Mental Hygiene For State Registrar 43252 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** MICHELLE MINTER DEC. 28, 2008 7:30 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MONTGOMERY SILVER SPRING HOLY CROSS HOSPITAL 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 ▼F Months Days Hours 69 JUNE 14, 1939 WASH. Director 579-54-0631 D.C. Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location 28a-f show llem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, it at which Examination in other traumatic event, it at which examination is a second of the control of the con 1 Yes 2 □ No Funeral Director MONTGOMERY SILVER SPRING MD. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20903 U.S.A. 8500 NEW HAMPSHIRE AVE. #437 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ▼ No Black, White, etc. 1 ☐ Never Married 2 Married altimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🕅 No Specify: Specify. Completed by 3 Widowed 4 Divorced WHITE 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) ADMINISTRATOR JOB PLACEMENT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be h and Mental h UNK. RICHARD **IHLDER** 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 Health a MINTER/HUSBAND 8500 NEW HAMPSHIRE AVE. #437, ROBERT SILVER SPRING, MD. 20903 permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 5 Other (Specify) 12-30-2008 4 □ Donation CHAMBERS CREMATORY RIVERDALE, MD. 21. Signature of Fuperal Service Lice 22. Name and Address of Facility
CHAMBERS FUNERAL HOME & CREMATORIUM, P.A. Chambura M00091 5801 CLEVELAND AVE., RIVERDALE, MD.20737 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** a. MULTI-ORGAN FAILURE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed SEVERE COLITIS and burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical the use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 🗓 No Month Day Year 5 Other (specify) the detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 2 pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 😾 Unknown Be Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy performed? yes 2∑No certificate 1 ☐ Yes funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1

Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death Funeral Director: the 6 ☐ Could not be 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) and manner stated within 2. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie D0063343 DEC. 28, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RUBAN, M.D. 1500 FOREST GLEN RD., SILVER SPRING, MD. 20910 IRINA 31. Date filed (Month, Day, Year) Registrar's Signature State DEC 30 Registrar 2008

43253 State of Maryland / Department of Health and Mental Hygien ? Certificate of Death 1 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 2008 December 29 2:30 Phung Luong Mach /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Nursing Center Rockville Montgomery Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year) 1 □ M 2 🗓 F Months Days Hours Min. 86 January 1,1922 Vietnam Director 586-34-5627 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Director North Potomac MD Montgomery 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? or items 23a or United States 20878 11301 Freas Drive by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify. Specify: Asian 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Medic 2008. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housewife Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ha Thi Hong Luong ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11301 Freas Drive North Potomac, MD. 20878 Sunhwa Chong (Daughter) 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Jan. Date 03 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Cypress Lawn Cemetery 2009 4 Donation 5 Dother (Specify) 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service Licenses TRACYA 10 East Deer Park Drive Gaithersburg, MD. 20877 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Months Stroke disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☒ No Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. ģ Atrial Fibrillation 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hypertension autopsy performed? 1 □ Yes 2 No certificate 1 ☐ Yes 2 No Diabetes Mellitus 25. Was case referred to medical Medical Certification: To Be 26. Place of Death (Check only one) examiner? Other: 4 🔀 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 🔽 Natural 5 Pending ours after death.

eral Director: A
filled in by the fu investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 29a, Certifier 🔼 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D28656 December 29, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ravi Passi M.D. 15225 Shady Grove Road #208, Rockville, MD. 20850 31. Date filed (Month, Day, Year) Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene 43254 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** DECEMBER 21, 2008 LAURALEE C. MEDLEY 1400 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGES CLINTON SOUTHERN MARYLAND HOSPITAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Y Social Security Number 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** Hours Year Days Months 1 ☐ M 2 😿 F 1932 WASHINGTON, DC 577-46-3612 **Director** 76 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at Director PRINCE GEORGES 1XYes 2 □ No MD ACCOKEEK 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 0 20607 UNITED STATES 17101 LIVINGSTON ROAD 23a Funeral items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 'natural", or 1 □Yes 🎾 No Specify: þ Specify: BLACK 3 Widowed 4 □ Divorced Completed Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, ITe M. College (1-4or 5+) Elementary/Secondary (0-12) ENVIRONMENTAL SERVICES LAUNDRY SUPV. HEALTH CARE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MARY LUVENIA WASHINGTON CLARK JAMES CLARK 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 5715 PLANTER ROAD, FORT BELVOIR, VIRGINIA 20748 DIANE RIVERS/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State N Burial 2 ☐ Cremation 3 ☐ Removal from State RESURRECTION CEMETERY DEC 30, 2008 CLINTON, MARYLAND 4 □ Donation 5 □ Other (Specify) 21. Statuture of Funcial Service Licens THORNTON FINERIAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MD 20640 LYDIA C. THORNTON JOHNSON 23a. Part1. Enter the disease, or complications that caused the death , Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on early line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed sician and burlal-tran Due to (d Box 68760. attending physician for use as the buris Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) 2 □No signed by the a □Yes P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u></u> 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s was ...
autopsy
performed?
Ves 2 \( \bar{\pi} \) No certificate 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 **D**No dire 1 ☐ Yes 1 🖄 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manyer of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 / Natural death. 1 ☐ Yes 2 ☐ No s after death.

I Director: / 2 Accident 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Dil completely filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29b. Signafure and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2208 Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Laxmi Berwa</u> 7503 Surratts Road, Clinton MD 20735 State Registrar

Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 Department of Health as Importent: If Item 27 is eny injury or other trau once. **Physician** /Medical Examiner

1 - For State Registrar

10a State

Maryland

12

**Physician** 

/Medical

Examiner

Directo

Funerai

Completed by

Be

**Funeral** 

Director

Item 27 is marked other then "natural", or items 23a or 28a-f show other traumatic event, the Medical Exeminar must be notified at

the Maryland

within 72 hours after

12 should be filed within 7 h and Menta! Hygiene.
7 is marked other then "n

certificete To the Hospital or Attending Phys within 24 hours after death.
To the Funeral Director: After this completely filled in by the funeral di

P.O. Box 68760.

Division of Vital Records.

24A42

shock, or heart failure. List only of	one cause on each line		1 / .		Interval Between
Immediate Cause (Final disease or condition resulting in death)	a	oney an	tey deler		Onset and Death
	Due to (or as a conse	quence of the Mills of the Mill	elliter		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conser	querice of):			
resulting in death) Last	Due to (or as a consect.	quence of):			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregn 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	al death 3 □Ectopie	: pregnancy (specify)		23d. Date of delivery Month Day Year
Part II. Other significant conditions of		sulting in the underlyin	g cause given in Part I.		use contribute to the cause of death?  No 3 Probably 4 Unknown
0'				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No
25. Was case referred to medical			26. Place of De	eath (Check only one)	-
examiner? 1 ☐ Yes 2 📉 No	Hospital: 1 ☐ Inpatient 2 ☐	]ER/Outpatient 3□	DOA Other: 4 Nursing	Home 5 ☐ Residence	6 ☐Other (Specify)
27. Manner of Death 1 □ Natural 5 □ Pending 2 □ Accident investigation		28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how inju	ry occurred
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At I building, etc. (Special	nome, farm, street, fac ify)	tory, office	28f. Location (Street a. City or Town, Stat	nd Number or Rural Route Number, e)
29a. Certifier 1 Certifying Phy (Check only Medical Examone)	ysician: To the best of my kn iner: On the basis of examin and manner stated.	owledge, death occurr ation and/or investigat	ed at the time, date and place ion, in my opinion, death occ	e, and due to the cause(s curred at the time, date an	c) and manner as stated, d place, and due to the cause(s)
29b. Signature and title of certifier	Jeuthel, N	n	29c. License number	29d. Da	ate signed (Mgnth, Day, Year)

State Registrar

ienter Ste 302

Waldorf. Md 2060+

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

12070 Old Line

31. Date filed (Month, Day, Year) DEC 2

Type of I that in Black Machine ming Theory in achine with Dally.	122
State of Maryland / Department of Health and Mental Hygien 008	432

		71/							Die SML	10/2	29/08	
	1	1/11-	1				DB	6576		/	-/-	
Mo	29b. Signature and title	e of certifier	~ /	,		25	9c. License	number	29	d. Date si	gned (Month,	, Day, Year)
Lacipa	29a. Certifier (Check only 25 one)	Certifying Phy Medical Exem	ysician: To the best iner: On the basis of and manner st	ol examina	owledge, death ation and/or in	h occurre vestigatio	d at the time on, in my op	ne, date and place pinion, death occu	e, and due to the ca urred at the time, da	use(s) and te and pla	manner as a ce, and due	stated. to the cause(s)
Cortification			building, e	tc. (Specif	fy)				City or Town.			
200	2 Accident 3 Suicide	Could not be determined	28e. Place of In	jury - At h	ome, farm, str			20,10	28f. Location (Str.	eet and No	umber or Rur	al Route Numb
20	27. Manner of Death	5 Pending investigation	28a. Date of Inj (Month, Da	ay Year)	28b. Time of Injury	f M	28c. Injury Work	rat ⟨? Yes 2 □ No	28d. Describe hor	v injury oc	curred	
F	1 ☐ Yes 2 No	-	Hospital:		ER/Outpatien			4   Nursing r	Home Resider			rfy)
a	25. Was case referred examiner?	<b>-</b>	Haenital:				10.		ath (Check only one	)		
potolomo									autopsy perform 1 Yes	ed?	death?	
tolo									24a. Was an autopsy	24	b. Were aut	opsy findings a ompletion of ca
									DE Ye	2 □ N	o 3∏Pro	bably 4 □U
0 74		nt conditions co	ontributing to death t	out not res	sulting in the u	nderlying	cause give	en in Part I.	23e. Did tob	acco use o	contribute to	the cause of de
Obversion/Medicion	1 ☐ Yes 2 ☐ N 9 ☐ Unknown		4□ Pregnant a 9□ Unknown	ume of d		Other (s	specify)					
lan/A	23b. Was decedent pri	egnant	23c. If yes, outcome	2 Feta	ıl death 3 ☐		pregnancy			23d.	Date of deliving Month	rery Day Y
Pol	IF FEMALE:											
0			d						,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
Evaminar	that initiated events resulting in death) Last		c. Due to (or as	a conseq	juence of):							
a lu	Sequentially list condit if any, leading to imme cause. Enter Underlyii Cause (Disease or inju that initiated events	ng d	Due 10 (01 25	, a conseq	judnic <del>a</del> utj.							
9-1	Sequentially list condit	ions,	b. Due to (or as	a consen	uence of):							
l r	resulting in death)		Due to (or as									
	Immediate Cause (Fin disease or condition	al	a	- hro	NIC Ob	STRU	TIVE	PUNMONA	MRY DISEA	LE		YEAR S
	23a, Part1. Enter the c shock, or heart fa	diseas or comp illure. List only o	lications that cause ne cause on each l	d the deat ine.	h. Do not ent	er the mo	de ol dying	g, such as cardiad	or respiratory arre	st,		Approximate Interval Betw Onset and Di
d	) er	us Kell	ly raskin					Street			2180	
oute.	21. Signature of Funer	al Service Licens	500					s of Facility	Bounds F			
	1 ☐ Burial 2 🖾 C 4 ☐ Donation 5 [		Removal from State )					arva 12-	29-08 D	elman	Del	aware
	20a. Method of Disposi	tion		20b. F	Place of Dispo	sition (Na	ame of other place	a)			on - City or T	own, State
	Cindy Norf						,		Salisbury	•		
F	Charles 19a. Informant's Name	Relationship (T	ype, Print)		Landor		ss (Street a	Henriet and Number or Ru	ta ural Route Number,	City or To	Mars wn, State, Zij	
a		n, MIGUIO, LASI)			Ionla					ander our		ha11
		st, Middle, Last)			Certif	tled	Nurs:	ing Assi 18. Mother's Nar	stant ne (First, Middle, M		spital	
Completed	Elementary/Seconda	, ,	College (1-4or	5+)						TJ = -		
pote	15 (Specify o	. Decedent's Edi	ucation de completed)		16a. Deced	dent's Usu kind of w	ual Occupa ork done d	ution Juring most of wor	rking	6b. Kind o	f Business/Ir	ndustry
À	3 ∰Widowed 4 □	_	If Yes, Give Year or Dates:			1 🗆 Yes	2⊿No	Specify:		Spe	ocify: Wh	ite
Funoral Director	11. Marital Status 1 ☐ Never Married	2 Marned	12, Was Decedent Armed Forces? 1   Yes 2   X	)				n, Mexican, Puert	pecify Yes or No- o Rican, etc.)		Black, White,	
0	322 Prince	eton Ave		Eveni: II	6 10:	Mac		21804	noody Voc at No	USA	A Race - Ameri	can Indian
S. C.	10e. Street and Numbe					10f. Zi	ip Code		10		of What Cou	ntry?
1	MD V	Vicomico		Sa	alisbuı	ry						1 🗌 Yes
		b. County		10c. Cit	y, Town or Lo	cation						10d. Inside City
r	216-14-2287 Usual Residence of De			87					June 21,	1921	Mary	land
ı	5. Social Security Numb	1[	x 7. Ag □M 2 1 F		last birthday) Yrs.	Months	Days	Hours Min.	8. Date of Birth (Month, Day,			place (State or ntry)
, wh	322 Prince						Salis		100 (5:11	W	icomic	
ine	4- 5	t institution, give	street and number)			4b. City	, Town, or	Location of Death	h	4c. Cou	inty of Death	
	Mable	I	sabelle			Mars	sh		December	26,	2008	11:45
ciar lica	Mable								Month	Day	Year	1

State of Maryland / Department of Health and Mental Hygien 2008 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 28, 2008 MATTHEWS Α December ROLAND LESLIE /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Crisfield Somerset McCready Memorial Hospital If Under 1 Year | If Under 24 Hrs Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 M 2 □ F Yrs. July 5, 1913 Maryland 95 Director 213-22-5321 Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland I and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State iral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 X No Directo Westover Somerset Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 29608 Kingston Lane
11. Marital Status

12. Was Decedent Ever in U.S. Armed Forces?

Armed Forces? USA 21871 Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married White 1 ☐ Yes 2 No Saltimore, Maryland 21215-0036 Specify Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Canning Company 8 Owner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be <u>Bessie Frances Nonemaker</u> ဥ Charles Foster Matthews 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 st Department of Health and Important: If Item 27 is ir any injury or other traum once. 29608 Kingston Lane - Westover, MD 21871 (Wife) Elizabeth Matthews 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 3 ☐ Removal from State Rehobeth Baptist Cemetery 12/30/08 Rehobeth, Maryland 21. Signature of Funeral Service Licensee

22. Name and Address of Facility

BRADSHAW &

Mary Beth Bradshaw-Pruitt

306 W. Main Street - Crisfie

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. BRADSHAW & SONS FUNERAL HOME - Crisfield, MD 21817 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 10 C **Physician** /Medical Due to ( as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of) physician Physician/Medical the nse 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy for ( Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, \$ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s 2 XNO certificate 1☐ Yes Division or Vital Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2**X**No 1 Minpatient 2 □ ER/Outpatient 3□ DOA ပို 1 ☐ Yes 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After Certification: (Month, Day Year) Injury To the Hospital or Attending 1 Natural
2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours after To the Funeral Dire 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) BARAL 30. Name and address of person who completed cause of death (Item 232) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 0 08 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month DECEMBER 2008 2046 MARY PATTERSON MARGARET /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE MONTGOMERY If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Davs | Hours | Min. | (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🛣 F Director Sept. 18, 1916 Pennsylvania 185-03-8809 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ir than "natural", or items 23a or 28a-f sho Director 1 ☐ Yes 21K No Maryland Montgomery Montgomery Village 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 19947 Spur Hill Drive Funeral 20886 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 "natural", or 1 ☐ Yes 2 🛣 No Specify: þ 3
☑ Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 721 (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 College Clerk marked other permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important; If item 27 is marked other any Injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ Chester Mason <u>Marga</u>ret Loftus 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret A. Desonier/Daughter 19947 Spur Hill Drive, Montgomery Village, MD.20886 Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 12/27/2008 Alexandria, Virginia 22. Name and Address of Facility DeVol Funeral Home ure of Funeral Service License ▶ #40 East Deer Park Dr., Gaithersburg, MD. 20877 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** MYOCARDIAL disease or condition resulting in death) INFARCTION /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events and the cause of t ner Due to (or as a consequence of): be executed Exami physician and s the burial-trans resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical law requires that the death certificate attending p for use as use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year 5 Other (specify) P.0. the 9 Unknown 9 ☐ Unknown by signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an as 2 s autopsy perform page certificate 2 No 1 □ Yes 2 No 1 ☐ Yes Physician: director 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) (Specify) 1 Yes 2 No Hospital: 은 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After thi 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: 28d. Describe how injury occurred or Attending Natural 5 ☐ Pending investigation ours after death.

neral Director: A
filled in by the ft death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital o within 24 hours aff Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Discretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Discretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0064502 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BRIAN CARPENTER 9901 MEDICAL CENTER DRIVE ROCKVILLE MD 20850 31. Date filed (Month, Day, Year) Registrar's Signature State DEC 3 0 Registrar 2008

State of Maryland / Department of Health and Mental Hygiene 0 0 8 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December 28, 2008 Physician Nancy 2:00 DM Lee Pattee /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3690 Brookwood Dr. White Plains Charles | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Young) | Hours | Min (Month, Day, Young) | February 0, 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Months 1 M 2 Gr 204-36-7157 PA Director Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits show 10a. State d other than "natural", or items 23a or 28a-f sho event, the Medical Evanirer must be notified at Director MD Charles White Plains 1 ☐ Yes 2 ™ No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20695 3690 Brookwood Dr. USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2√□No Specify: Specify: 2 White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; If item 27 is marked oth any injury or other traumatic event Be Thomas Clayton Howard Marguerite Louise Soubeyrand 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anthony Steven Pattee/Husband 3690 Brookwood Drive, White Plains, MD Method of Disposition

20b. Place of Disposition (Name of cametery, crematory or other place)

20c. Location - City or Town, State cametery, crematory or other place)

1 Burial 2 Cremation 3 Removal from Stater inside descriptions. Crematory 12/23/08 Charlotte Hall, Md. 20a. Method of Disposition 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses M00174 22. Name and Address of Facility
AREHART-ECHOLS FUNERAL HOME, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. P.O. Box 567 LaPlata, Md. 20646 Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if the list is the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of the death certificate be executed and burial-trar Due to (or as a consequence of) P.O. Box 68760 attending physician Physician/Medical the nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy for Month Day Year 5 Other (specify) cate has been signed by the a page 2 should be detached for ☐Yes 2 ☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed certificate has been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) Hospital: 1 | Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 filled in by the funeral 27. Manner of Deatl 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certification: After Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No s after death. 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral I 29a. Certifier +ECertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Krishan Mathur, M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 32. Pagistrar's Signature 31. Date filed (Month, Day, Year) State **DEC 29** 2008 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 43260 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** 2008 December 5:05 P Elvira Irabien Riva /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bethesda Montgomery Suburban Hospital 8. Date of Birth (Month, Day, Year 04/19/1927 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days Hours Min. Months 1 M 2 K Director Mexico 262-70-7850 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show a migraturi if Item 27 is marked other than "natural", or items 20a or 28a-f show any injury or other traumatic event, the Medical Experience must be notified at once. MD Chevy Chase Director Montgomery 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 20815 4615 North Park Avenue #719 United States Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 Ves 2 □ No Specify: Cuban Specify: White ≥ 3 NWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Inter-American Elementary/Secondary (0-12) College (1-4or 5+) Development Bank Officer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elvira de la Riva Alberto Irabien Sr. ပ 19a. Informant's Name/Relationship (Type. Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margarita M. Riva-Geoghegan 11037 Cedarwood Drive Rockville, MD 20852 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 12/29/2008 National Crematory Falls Church, Virginia 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Lipensee 22. Name and Address of Facility Joseph Gawler's Sons Inc. William 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) neumonia **Physician** /Medical (or a a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): sician and burial-transit Due to (or as a consequence of): within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial Division of Vital Records, P.O. Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 C Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Year Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? res 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) Hospital: 1∐Yes 2∏rNo 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide the Hospital or To the Hospital of within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical anner stated. 29c License number 000 6 2 4 3 5 29b. Signature and title of certific 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) lolelular Dr. Rockville, MD 20850 31. Date filed (Month, Day, Year) Registrar's Signature State DEC 3 Registrar 0

DHMH 17 Rev 1/2001

12/23/08

VIER'I PIVE

State of Maryland / Department of Health and Mental Hygien 20 Certificate of Death 2. Date of Death Month Decedent's Name (First, Middle, Last) Day Year **Physician** URIENZIA 10:55 AM ODERIS KAYMOND 26-2 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wicomico SAL SOURY AVE 1016 1VER If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1⊠M 2□F 64 216-44-8213 Director DELAWARE Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Inpertment of Health and Mental Hygiene.
Important: if item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic svent, if a Medical Examinar must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MARYLAND Alisbury 1⊠Yes 2 No Wicomico Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? USA 21804 10161 VIER Be Completed by Funeral 12. Was Decedent Ever in U.S. Amped Forces? 1 Yes 2 □ No IVes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: Black 17 Year or Dates: 1965-1971 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) NONE LABORER 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) OFERRA? LANTHA Rebert 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wife DIG IVIER KOSALINC KODERIS DALISBURY 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State or other place) 1 ⊠Burial 2 □ Cremation 3 □ Removal from State \* 4 □ Donation 5 □ Other (Specify) 6.11 1-3-2009 ARMANE EME ERM 21. Signature of Funeral Service Licensee 22. Name and Address of Facility lady STEWAR Stewar FUNERA HOME 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospitel or Attending Physicien: The law requires that the death certificate be executed for use as the burial-transit the attending physicien and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2.8 No 3 ☐ Probably 4 ☐Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? 2 No 1 Yes 2 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 Yes 20 No 1 Inpatient Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident To the Funeral Director: filled in by the 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical within 24 and title of gertifier 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 24 States of Maryland / Dapages 9,001/149/69 and Mental Hygiene 008 43262 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) December 26, 2008 **Physician** 6:05A Margaret M. Riley /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Timonium
If Under 1 Year | If Baltimore Stella Maris Health Care 8. Date of Birth (Month, Day, Year) Sept. 23, 1926 9. Birthplace (State or Foreign Country) New York If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Min. 1 □ M 2 🛣 F Months Davs Hours 082-38-7064 Director 82 Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City. Town or Location 10a. State 10b. County r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 XYes 2 No Director Baltimore Maryland 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number U.S.A. 7102 Sheffield Road 21212 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 Specify. Specify: White Completed by 3√2 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Health Care 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alice Anglim Joseph Sullivan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7102Sheffield Road, Baltimore, Maryland21212 Margaret Riley/Daughter 27 permit. Pages 1 and Department of Heal Important: If item 2 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 12/29/08 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Calverton, New York CalvertonNationalCem. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Marzullo Funeral Chapel, P. A. Michael marquelle 6009Harford Road, Baltimore, Maryland21214 23a. Part 1. Enter the disease, or completions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** OSKUMBLUM disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine been signed by the attending physician and should be detached for use as the burial-transi Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 5 Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 □ Yes 2 **X**No of Vital ieral Director: After this certific filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After Division 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29b. Signature and the of certific 29d. Date signed (Month, Day, Year) 29c. License number 21507 59 2008

State Regist<u>rar</u>

MARGARET RILEY

TIMONIUM

MD

21093

2300 DULANEY VALLEY ROAD

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARIAM BAKIR CRNP
31. Date filed (Month, Day, Year)
JAN 14 2009

Melvin Joseph Smith

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 43263

	1- For State Registrar	Cer	rtificate of Death		Reg	. No.	
Physician ledical Examine	1. Decedent's Name (First, Middle,L	,			December 2		3. Time of Death 1643 hrs
	4a. Facility Name (if not institution, of 5426 Cassons Road	ive street and number)	4b. City, Town Cambridg	, or Location of Death ge	n	4c. County of Dea Dorchester	th
Funeral Director	219-34-6895	Sex 7. Age (In yrs. I: <b>X</b> M 2 F <b>69</b>		Year If Under 24Hrs Days Hours Mir	_	` 1 c	rthplace (State or Foreign ountry)
any	Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or Location				10d. Inside City Limits
*	MD Dorche	ster Can	abridge				1 Yes 2 X No
the Maryland a or 28a-f show tified at once.	10e. Street and Number 5426 Cassons	Neck Road	10f. Zip Coo	21613	100	g. Citizen of What Co	untry?
Baltimore, MD 21215-0036  permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Narhell Hygiens. Department of Health and Narhell Hygiens. If then 7 is marked other than "natural", or items 23a or 28a-f sho important: If then 7 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once in the Na Completed by Finneral Director	11. Marital Status 1 Never Married 2 Marri 3 Widowed 4 X Divorce	12. Was Decedent Ever in U Armed Forces? 1 X Yes 2 No lf Yes, Give Year		iban, Mexican, Puerto		14. Race - Ame White, etc.	rican Indian, Black,
5-0036 led within 72 hours after litygiene. other than "natural", the Medical Examiner	15. Decedent's Education (Specify Elementary/Secondary (0-12)	or Dates:	16a. Decedent's Usual Docuduring most of working	upation (Give kind of		16b. Kind of Business	
vithin ene.	12		Truck Dri				ortation
215-0036 be filed within 7 mal Hygiene. rked other than ent, the Medica	Joseph Smith			Grace	e (First, Middle, Ma k Kunak		
MD 21 ad 2 should I alth and Mer an 27 is man	Timothy W. Smit	h – Son	19b. Mailing Address (S	int Clair	Bridge R	d., Jarret	21804 ctsville,MD
Baltimore, MD 2121 permit Pages 1 and 2 should be fi Department of Health and Mental Important: If then 21's marked injury or other traumatic event,	20a. Method of Disposition  1 Burial 2 X Cremation  4 Donation 5 Other Spec	Removal from State	Place of Disposition (Name o crematory or other place)  I Shore Cremat	12	Date 2/24/2008	20c. Location - City of Cambridge	
Balti permit Departm Importa injury o	21. Signature of Funeral Service Lic  Todd A. Mielk	ensee	22. Name and Add <b>Hudson</b>	Road, Can	d Shore bridge,M	Cremation D 21613	Ctr., 2272
Physician	23a. Part I. Enter the disease, or co failure. List only one cause on	mplications that caused the death each line.				st, shock, or heart	Approximate Interval Between Onset and Death
Examiner	Immediate Cause (Final disease or condition resulting in death)	a. Atherosclerotic Cardiov  Due to (or as a consequence of		olicated by hypo	thermia		Death
no.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	b. Due to (or as a consequence of	of):				
led nisit	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of	of):				
760, cate be executed physician and he burial - transit	UNPENDED  IF FEMALE:	AMENDED #21 pe	er fh,g887,01/	14/09dhb			
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknot	23c. If yes, outcome of preg 1 Live birth 4 Pregnant at time of do	2 Fetal death	3 Ectopic pregr	nancy	23d. Date of delive Month	ery Day Year
that the death of the attended for us		9Olikilowii	resulting in the underlying cau	use given in Part I.			to the cause of death?
ires that the signed by deed detach							obably 4 Unknown
Vital Records, P.O. hysician: The law requires that the this certificate has been signed by a director, page 2 should be detacted.					24a. Was ar autops perforr 1 Yes 2	y prior to med? death?	autopsy findings available completion of cause of Yes 2 No
Vital Recysician: The his certificate director, page	25. Was case referred to medical examiner?	Hospital:		Other Nurs			-
n of Virding Physical  After this funeral dir.	1 V Yes 2 No	28a. Date of Injury	FOUND	Injury at Work?  Yes 2 V No	28d. Describe he	Residence 6 Othow injury occurred osed to cold envi	
Division  pital or Attendious after death.  reral Director: /	2 Accident Investig 3 Suicide 6 Could r	Dec 21, 2008  28e. Place of Injury - At h	1643 hrs nome, farm, street, factory, off		or Town, St		Rural Route Number, City
Division To the Hospital or Attend within 24 hours after death To the Functual Director: completely filled in by the	Check only 1 Certifying Phys	sician: To the best of my knowled ner: On the basis of examination	dge, death occurred at the time	ne, date and place, ar inion, death occurred	nd due to the cause	e(s) and manner as st	ated.
0. 1 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	29b. Signature and the of confiner	and manner stated.		cense number		29d. Date signed (A	
HI OCNIE		no completed cause of death (Iter	m 23a)		MD 04004	, 0, 200	
Stat	a 31. Date filed (Month, Day, Year)	Deputy Chief Medical Exa 32. Registrar's Signal		reet, Baltimore,	WD 21201		
Registra	1 1 4 1 4 /1	2009 Cineur	S. Sarres				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible State of Maryland / Department of Health and Mental Hygiene 0 1 - For State Registrar MEND#2+23aIIperMD, 12/30/08, HMW, McCertificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 18 Year James Frederick Stewart December 17, 2008 11:37Å 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery 9. Birthplace Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) . Age (In yrs. last birthday) 5. Social Security Number Min. Months Davs Hours 1 X M 2 □ F 167-34-3994 May 16, 1942 Ohio Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ∐Yes 2 🔀 No Hyattsville Maryland Prince Georges 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 900 Linwood St 20783 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1√7Yes 2☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 □Yes 2 No Specify 3 ☐ Widowed 4 ☐ Divorced 1964 Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Firefighter D.C. Fire Department 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Sherman Stewart Ernestine Lincoln 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lady Stewart/Wife 900 Linwood St, Hyattsville, MD 20783 20c. Location - City or Town, State 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) N Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery Dec 27, 2008 Brentwood, MD 22. Name and Address of Facility Hines-Rinaldi Funeral Home 21. Signature of Funeral Service Licensee con 11800 New Hampshire Ave, Silver Spring, MD 20904 23a. Part 1. Enter the disease, or shock, or heart failure. List complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPSIS disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Lause (Unsease of Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year 1 ☐ Yes 2 ☑ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown CONGESTTVE RENA 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? HYPOTENSION 1 ☐ Yes 2 ☐ No 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify)

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

10a State

**Funeral** 

Director

28a-f show

ö 23a

items

ō

"natural"

is marked other than

permit. Pages 1 and 2 s Department of Health an Important: If item 27 is 1 any Injury or other traur once.

filed withir Hygiene.

be

72 hours after

Baltimore, Maryland 21215-0036

Director

Funeral

þ

Completed

Be

မ

Examiner

traumatic event, the Medical Examiner must be notified at

law requires that the death certificate be executed physician and s the burial-tran and attending p

Box 68760,

P.O.

Division of Vital Records,

been signed by the should be detached certificate has birector, page 2 sl Ė this After the funeral

or Attending he Funeral Director: Af the Hospital completely

Physician/Medical 2 Completed Be Certification: To

within 24 9

State

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and file of certifier

5 ☐ Pending investigation

6 ☐ Could not be

determined

 $M \cdot D$ .

28a. Date of Injury (Month, Day, Year)

29c. License number D 59121

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

11/2008

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MALIK TASNEEM 31. Date filed (Month, Day, Year)

1 Tes 2√2 No

27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

DEC 3 0 2008

CARRILL AVENUE TAKOMA PARK, HD 20912 7600 Registrar's Signature

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #1 Per PHY G909 11/18/10 JH
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Robert Wynn Singleton 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** -ROBERT 1310 M December 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Shady Grove Adventist Hospital Rockville If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** M 2□ F Months 59 Director June12,1949 New York 121-40-3532 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Marical Evantical Evantical Examples on the once. MD Montgomery Village 1 Yes 2 □ No Director Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20886 U.S.A. 20024 Giantstep Terr Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Yeer or Dates: 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Black 3 Widowed 4 Divorced 71-75 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) 4 Vrs Elementary/Secondary (0-12) Self-employed Music Producer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lula Gibson Willie Singleton, Jr ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20024 Giantstep Terr, Montgomery Village, MD Paula Singleton (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Ardent Crematory 12.30/08 Hanover, MD 21. Signature of Funeral Servi Lic - ee 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. HEART FAILURE Approximate Interval Between Onset and Death **Physician** /Medical 5 days Due to (or as a consequence of): Examiner PAILURE RENAL HIUTE Sequentially list conditions, if any, leading to infine date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit CANCER PROSTATE Division of Vital Records, P.O. Box 68760, cgs METASTATIC Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 4 Pregnant at time of death 5 Other (specify) □Yes 2□No sate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, page 1 □Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 □Yes 2 □No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CENTER DR 9901 SIREESHA JALLI MEDICAL 31. Date filed (Month, Day, Year) 32 egistrar's Signature State DEC 3 0 Registrar 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Registrary/FND#27perME, 12/31/08, BMW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 420P Rebecca **Physician** ZOE 8 Dec /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner MD. HOWARD COUNTY GENERAL CCLUMBIA HOWARD If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. May May 1978 Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** 30 1 □ M 2 🗓 F 219-06-5252 Director Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Maryland Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21043 United States 7608 Stony Creek Lane Completed by Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. white 11. Marital Status 1 □Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 Specify 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than " any Injury or other traumatic event, the Ma Elementary/Secondary (0-12) College (1-4or 5+) Lawyer Law 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ronna Wilons Perry Sandler ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11932 Canfield Road, Potomac, MD Perry Sandler, Father 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Judean Memorial Gardens 12/30/08 Olney, MD 22. Name and Address of Facility Torchinsky Hebrew Funeral Home 21. Signature of Funeral Service Licensee Torchinsky Hebrew Funeral Home 254 Carroll St., NW, Washington, DC 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) RIPLE IM PRODUCT - PILLAK **Physician** Cerchral anoxia /Medical Due to (or as a consequence of): Examiner Cardiopulmonaro arres Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed INTOXICATION Alcoho PROVED BY MEDICAL EXAMINER Due to (or as a consequence of): Physician/Medical CERTIFIC IF FEMALE: After this certificate has been signed by the attendin funeral director, page 2 should be detached for use: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year Day 4 ☐ Pregnant at time of death 5 Other (specify) Part Ii. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Deprecsion 1 Yes 2 No 3 Probably 4 Unknown Medical Certification: To Be Completed Anxiety 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 Who 1 ☐Yes 2 ☐No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Injury 1630 1 □Yes 2 No UNKNOWN 2 Accident 3 ☐ Suicide Could not be 28e. Place of injury: At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Bural Boute Number City or Town, State) determined 4 Homicide Honey lune Certifying Physician: To the best of my knowledge death occurred at the time, date and place, and due to the cause(s) and meanner as stated. 29a. Certifier

P.O. Box 68760 Division of Vital Records, within 24 hours after death.

To the Funeral Director: A
completely filled in by the fi

DHMH 17 Rev 1/2001

(Check only

29b. Signature and title of certifier

William Boyc

DEC 3 0 2008

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Registrar's Signature

Gen

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

DU043662

ttospetal 5755 Cedar Lane, Columbia, MD

29d. Date signed (Month, Day, Year)

21044

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 43267 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death December 27, 2008 1:45A M Erlene Physician Sandberg W. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Silver Spring Montgomery Holy Cross Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb. 24, 1910 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days 1 □ M 2 ▼ 98 California 546-52-6243 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he national once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County College Park Mərylənd Prince George's 14 Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 7312 Radcliffe Drive 20740 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Z No If Yes, Give Year or Dates: 14. Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married White 1 ☐ Yes 2 X No Baltimore, Maryland 21215-0036 Specify: 3 X Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Williams Calista Cunningham 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7312 Radcliffe Drive College Park, Maryland 20740 Stephen R. Sandberg -son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan Crematory 12/30/2008 Alexandria, Virginia 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Possible Sepsis /Medical Due to (or as a consequence of): **Examiner** Urinary Tract Infection Sequentially list conditions, it any, leading to immediat cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be execu within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Pre Renal Azotemia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? 1 ☐ Yes 2 X No 1∐ Yes 2X No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 🖎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D54566 December 28, 2008 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sunitha Bhogavilli, M.D. 9801 Georgia Avenue,#1-17 Silver Spring, Maryland 20902 31. Date filed (Month, Day, Year) 32 Registrar's Signature State DEC 3 0 Registrar 2008

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dec. 18, 2008 **Physician** 12:20 PM HOUSTON WILLIAM TAYLOR JR /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Rockville Under 1 Year | If Under 24 Hrs. Shady Grove Adventist Hospital 8. Date of Birth
June 24, 1946 9. Birthplace (State or Foreign Age (In yrs **Funeral** Days Hours Min. 1<del>∏</del> M 2□ F Maryland 219-48-0416 62 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director Gaithersburg MD Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number .S.A. 14. Race - American Indian, 20877 101 Odendhal Ave #217 Funeral death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Armed Foldes: 1 Types 2 Pp 966-If Yes, Give Pear or Dates: 1972 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Saltimore, Maryland 21215-0036 Specify: Specify: Black þ 72 hours 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) filed withi Hygiene. Lockheed Martin Computer Analyst 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) d 2 should be fill h and Mental H 7 is marked oth Be Grace Rebecca Coates William H. Taylor Sr. ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a important: If item 27 is any Injury or other tra Odendhal Ave#217 Gaithersburg,MD 20877 101 Grace R. Taylor-Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 □Removal from State Wet Cemetery 4 ☐ Donation 5 Other (Specify) 1/5/2009 Crownsville,MD MD 22. Name and Address of Facility Snowden Funeral Home, PA 21. Signature Funeral Service Live see 246 N. Washington St Rockville, MD20850 IEMA 23a. Part1. Enter the disease, or complications that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician VENTRICULAR FIBRILLATION /Medical Due to (or as a consequence of): Examiner MYOCARDIAL INFARCTION if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit MORBID OBESITY Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Tilnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Minknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 Yes 2 XNo 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 1 ☑ Natural 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) Injury 5 Pending investigation s after dea. ral Director: After 1 TYes 2 No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Dec. 18, 2008 D47093 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Martin Thai McGreivy, MD 9901 Medical Center Drive Rockville, MD20850 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar DEC 30 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** noss 1334 M Q Dec eresita 0 27 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 51. Monto 1116 Sprin Silver Date of Birth (Month, Day, Jan. 16, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9 Birthplace (State or Foreign **Funeral** 1 □ M 2 ▼ F Months Days Hours Philippines Jan. 213-66-0844 55 Ĩ953 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2X No Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 23a 20910 Philippines 1001 Spring Street, Apt. 1116 Funeral items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc filed within 72 hours after i Hygiene. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 6 1 ☐ Yes 2 🛣 No Specify: Asian þ 3 Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than any injury or other trainmatic. Elementary/Secondary (0-12) College (1-4or 5+) 4 Administrator Hospitality 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) æ Francisco G. Valeda Emilia Parilla 2 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2401 Epstein Court, Brookeville, MD 20833 Frank P. Valeda, Jr./Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Jan. 3, Metropolitan Crematory Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 2009 21. Signature of Funeral Service License 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SC Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease of injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) certificate be executed burial-tran Due to (or as a consequence of): physician at the burial Physician/Medical attending p for use as use as IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) P.O. I ed by the 9 Unknown s been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has birector, page 2 st autopsy performe 1 ☐ Yes 2 ☐ No 1∐Yes 2Д To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4  $\square$  Nursing Home 1XYes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this c funeral din 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation within 24 hours after death **√o the Funeral Director:** completely filled in by the f 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only

State

29b. Signature and title of confiler

31. Date filed (Month, Day, Year)

mo ome

32 Registrar's Signature

mo, ome

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

2101

29d. Date signed (Month, Day, Year)

			For State Registrar	State of	Maryland /	Depa Cer	artment of F tificate of	lealth a Death	and Me	ntal Hygio	eng 00	8	43270
	Physici: /Medic		1. Decedent's Name (First, Middle, La LEE	W.	W	OODS				. Date of Death Month ECEMBER		ear 08	3. Time of Death 7:45 A M
	Examin		4a. Facility Name (If not institution, giv Northampton Mano				4b. City, Town, o		of Death		4c. County of Frede		<
	Funeral Director		5. Social Security Number 312-18-6855	ex MM 2□F	7. Age (In yrs. last I 88	birthday) Yrs.	If Under 1 Year Months Days	If Under : Hours	Min.	Date of Birth (Month, Day, 1 April 23	rear)	Birthpl Coun Inc	ace (State or Foreign try) Lana
	the Maryland 28a-f show	Director	Usual Residence of Decedent  10a. State 10b. County  Md. Freder  10e. Street and Number	ick	10c. City, To	own or Lo				10	g. Citizen of Wh		0d. Inside City Limits 1  Yes 2  No  try?
036	be filed within 72 hours after death with the Maryland all Hygiane. All Hygiane. I hatturel', or items 23e or 28e-f show other than "naturel', or items 23e or 28e-f show event. The Medical Exprintment until be inclifted all	Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Dece Armed For 1 M Yes If Yes, Give Year or Da	2 □ No	'	Was Decedent of H f Yes, specify Cub	2170  Iispanic Origan, Mexican  Specify:	gin? (Speci	ify Yes or No- can, etc.)	Unite  14. Race- Black, Specify:	America White, 6	an Indian,
Maryland 21215-0036	filed within 72 ho Hygiene. sther then "natur ent, the Medical I	Completed by	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12) 12	College (1-		(Give life.	dent's Usual Occup kind of work done DO NOT use retire anager	during mosi d)			Auto De	ale	
/land	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the Ma	To Be	17. Father's Name (First, Middle, Last Frank - Wood					Eli	zabet	:h -	Hires		
Man	s 1 and 2 should f Health and Men Item 27 is marke other traumatic		19a. Informant's Name/Relationship (		1		ng Address <i>(Street</i> 2 Havenwo						<sup>Code)</sup> 20871
Baltimore,	permit. Pages 1 and 2 Department of Health a Importent: If Item 27 Is any injury or other trai <u>once.</u>		20a. Method of Disposition 1 ☐ Burial 2 【A Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Speci		State ceme	tery, crer	sition (Name of matory or other pla itan Cres	.	12/29	_	oc. Location - Ci Alexand	•	
Balti	permit. Departm Importe any inju		21. Signature of Funeral Service Lice	nsee Danke	^	22	Name and Addre Muriel I					ıd.:	20882
	Physician /Medical Examiner ithe prize transit	dicai Examiner	23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (	or as a consequence or a consequence	ce of):							Interval Between Onset and Death
P.O. Box 68	ath certifi attending for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	1☐Live bi	come of pregnancy inth 2 Fetal dea ant at time of death		Ectopic pregnanc Other (specify)	у			23d. Date of Month		ry Day Year
	n requires that the de been signed by the s should be detached	b	Part II. Other significant conditions		ath but not resulting		nderlying cause gr	en in Part I		23e. Did toba	1		e cause of death? ably 4  Unknown
I Records,	sicien: The law re certificate has bee irector, page 2 sho	Completed	ATRI	AL FIBE	21114760	ر				24a. Was an autopsy perform	ed? prid	or to con ath?	psy findings available inpletion of cause of
Vita	Physicien: r this certific ral director,	To Be (	25. Was case referred to medicat examiner? 1 ☐ Yes 2 Z No	Hospital: 1 🗆 li	npatient 2□ER/	Outpatier	nt 3□ DOA Ot	an 4		Check only one a 5 ☐ Resider	) nce 6 □Other	(Specify	1)
Division of Vital	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification; T	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	on	h, Day Year)	D. Time o	M 1	ry at rk? ∣Yes 2 □	No		v injury occurred		10
Divi	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the fune.		4 Homicide determined	280. Place buildir	of Injury - At home, ng, etc. (Specify)					City or Town,			
	the Host in 24 ho he Fune pletely fi	Medical	(Check only 2 Medical Exa		best of my knowled asis of examination ner stated.		vestigation, in my	pinion, dea		d at the time, da	te and place, and	d due to	the cause(s)
) ;	24 1 Som	Σ	29b. Signature and title of certifier		~		29c. Licens	3217	71	29	d. Date signed (		
			30. Name and address of person who	WIGH 7	00 00 32	9 6	Print)	ine 1	20	21753			
	Sta Regist		31. Date filed (Month, Day, Year)  DEC 3 0 200	32. R	egistrar's Signature	60	R)						

1	For State Registrar			State o	ot iviai	ryland	d / Dep <i>Ce</i>	artmen e <i>rtificat</i>	e of D	eath	a ivie	ntai Hy	giene Reg. No		08	43	27
1.	Decedent's Nam	e (First, Midd	lle, Last)								2	. Date of De	-			3. Time	of Death
		Ustick									D	Month ec. 2	8, <sup>Da</sup>	800	Year	7.4	0 A M
40	. Facility Name (				imbor)			1 Ab City	Town or L	ocation of D		CC. 2			of Death		0 11
	5600 Wis		-						vy Cha		cauı				omer		
	Social Security N		6. Sex			(In vrs I	ast birthday			If Under 24 F	Hrs. R	Date of Bi					e or Foreign
	011-20-7	852		M 2025F	_	86	Yrs.	Months	Days	Hours M	Min.	Date of Bi (Month, D ay 14	ay, Year) 19	22	Cou	souri	
-	a. State	10b. County	/			10c. City	, Town or L	ocation								10d. Inside	City Limits
	MD	Montg	omer	у		Chev	y Cha		0-4-				10- 0	diman of l	What Cou		es 2. <mark>T</mark> ANo
	e. Street and Nui							10f. Zip					-		What Cou		
L.	5600 Wis	consin						208							State		
11	. Marital Status  1 Never Marr  3 Widowed		rried	12. Was Dec Armed Fo 1 ∐Yes If Yes, Gi Year or D	orces? 2∏XNo ive		5.   13	. Was Deced If Yes, sped 1 ∐Yes		panic Origin? Mexican, Pu Specify:	? (Speci uerto Ri	fy Yes or No can, etc.)	0-	Bla	ce - Ameri ck, White, y: Wh:		
		15. Deceder	nt's Educ	cation			16a. Dec	edent's Usua	al Occupati	ion		- 1	16b. K	(ind of B	usiness/Ir	ndustry	
-		cify only highe	est grade	e completed)			(Giv life.	e kind of wor DO NOT us	rk done dui se retired)	ring most of	working						
	Elementary/Seco	ondary (0-12)		College (	1-40r 5+,	'	Home	maker					07	wn H	ome		
1:	7. Father's Name	(First, Middle.	, Last)	- <b>r</b>					1	8. Mother's I	Name (/	First, Middle					
	W. Lee U		,							Eugeni							
			ahia (Tia	nn Deint			10h Mai	line Address							Ctata 7	in Code)	
	9a. Informant's N					e		_	•	nd Number o			-				
	Charles		Will	iams .	Jr.	/ 	L5600	Wisc	onsin	Ave.							15
20	Da. Method of Dis 1 ☐ Burial 2	•	з□в	lemoval from	State	20b. Pl	ace of Disp emetery, cre	osition (Nar ematory or o	me of other place)		Dat				•	own, State	
	4 ☐ Donation					Nat		Crema	_			2008				h, Vi	rgini
2	1. Signature of Fu	uneral Service	-/	ee Wag						of Facility J		-					6
lin.		art fail List	t only on	cations at one cause on o	caused to each line	he death	. Do not e	nter the mod		such as car	diac or r	espiratory	arrest,			Approxin Interval E Onset ar	Between
d re	snock, or nea- mediate Cause isease or conditic esultling in death) equentially list co any, leading to in ause. Enter Unde ause (Disease Olsease) rat initiated events esulting in death)	art fail J.L. List (Final on Inditions, Inditions, Inditions Indigry Indigry	t only on	Atho	each line eros (or as a	cler consequ		Heart	de of dying,		diac or r	respiratory a	arrest,			Interval E	Between
S if can C th	mmediate Cause isease or conditic esculting in death) equentially list co any, leading to im ause. Enter Under ause (Disease or nat initiated events esculting in death) i	art faili. L. List (Final on Inditions, Indi	t only on	Due to  Due to  Due to	each line eros (or as a (or as a	cler consequ consequ consequ	rotic Hence of):		de of dying,		diac or r	respiratory a	arrest,	ond Da		Interval E	Between
Sif cac C th	mmediate Cause isease or conditic esculting in death) equentially list co any, leading to in ause. Enter Und ause (Disease or at initiated events soulting in death)	art faili. L. List (Final on Inditions, mediate priying injury s Last  t pregnant months?	t only on	Atho	each line eros (or as a (or as a  (or as a  introme or birth 2 grant at t	cler consequ consequ consequ	rotic lence of): lence of): lence of):		de of dying, Dise		diac or r	espiratory :	arrest,		ate of delive	Interval E	Between
Sif can Character the second s	mmediate Cause isease or conditic esculting in death) equentially list co any, leading to imause. Enter Unde ause (Disease or nat initiated events esculting in death) in the past 12 1   Yes 2 [	nditions, mediate erlying injury stast	t only on a b c d	Due to  Due to  Due to  Due to  Due to  Due to	exch line excos (or as a  (or as a  (or as a  utcome or birth 2 gnant at the grant of the component of the c	cler consequ consequ consequ f pregnat	rotic Hence of): Hence of): Hence of): Hence of): Seath 3 Heath 5	Heart □ Ectopic p □ Other (sp	Dise	ase	diac or r	23e. Did	tobacco	use conf	onth tribute to t	onset and onset	Year
Sif can Character the second s	mmediate Cause isease or conditic essulting in death)  equentially list co any, leading to in ause. (Disease or aut initiated events soulting in death):  FEEMALE: 3b. Was deceden in the past 12 1	nditions, mediate rilying injury stast	t only on a b c d	Due to  Due to  Due to  Due to  Due to  Due to	exch line excos (or as a  (or as a  (or as a  utcome or birth 2 gnant at the grant of the component of the c	cler consequ consequ consequ f pregnat	rotic Hence of): Hence of): Hence of): Hence of): Seath 3 Heath 5	Heart □ Ectopic p □ Other (sp	Dise	ase	diac or r	23e. Did 1 □	tobacco Yes 2	use conf	tribute to t	very Day	Year  Year  Unknown
Sif can Character the second s	equentially list coany, leading to limuse. Enter Unde ause (Disease or at initiated events esulting in death)  FFEMALE: 3b. Was deceden in the past 12 1   Yes 2 [ 9   Unknown art III. Other signification of the control of the contr	nditions, mediate rilying injury security securi	ions con	Due to  Due to  Due to  Due to  Due to	exch line excos (or as a  (or as a  (or as a  utcome or birth 2 gnant at the grant of the component of the c	cler consequ consequ consequ f pregnat	rotic Hence of): Hence of): Hence of): Hence of): Seath 3 Heath 5	Heart □ Ectopic p □ Other (sp	Dise	ase	diac or r	23e. Did 1 □ 24a. Was auto	tobacco Yes 2	use cont	tribute to to to to to contain to contain to contain to contain the contain to contain the contain to contain the contain to contain the c	very Day the cause obably 4 6	Year  Year  Munknowr
Si fi ca CC the re	equentially list co any, leading to image duse. Entire Under suse of condition of the control of	Inditions, mediate erlying injury stast  In pregnant months?	ions con	Due to  Due to  Due to  Due to  Due to	exch line excos (or as a  (or as a  (or as a  utcome or birth 2 gnant at the grant of the component of the c	cler consequ consequ consequ f pregnat	rotic Hence of): Hence of): Hence of): Hence of): Seath 3 Heath 5	Heart □ Ectopic p □ Other (sp	Dise	ase.		23e. Did 1	tobacco Yes 2 an psy primed? 2 🖾 No	use cont	tribute to t	very Day the cause obably 4 6	Year  Year  Unknown
Si fi ca CC the re	equentially list co any, leading to limuse. Enter Unde ause (Disease or at initiated events soulding in the past 12 1   Yes 2 1   Yes 3 2   Yes 3 1   Yes 3 2   Yes 3 1   Yes 3 2   Yes 3 1   Yes 4   Yes 5   Yes 6   Yes 6	nditions, mediate riving injury shart months?  The months on the months?	ions con	Due to  Due to  Due to  Due to  Due to	each line eros (or as a (or as a  (or as a  utcome or birth 2 gnant at t nown	cler consequ consequ consequ f pregnai Fetal ime of de	ence of):  Hence of):	□Ectopic p □Other (sp.	Dise	ase. in Part I.	Death (	23e. Did 1 □ 24a. Wasa perfi 1 □ Yes Check only	tobacco Yes 2 an psy ormed? 2 X No	use conf	tribute to to the second of th	very Day  the cause of the cau	Year  Year  Unknown
Siff CCC there	equentially list co any, leading to limuse. Enter Under ause. Chief under Under ause. Chief under Under ause. Enter Under ause. (Disease or lat initiated events soulting in death):  FEMALE:  3b. Was deceden in the past 12 1 □ Yes 2 [9 □ Unknown art II. Other significant III. Other signi	nditions, mediate erlying injury stast treegnant months?  Thought to The most on the most	ions con	Due to  Due to  Due to  Due to  Due to  Due to	each line eros (or as a (or as a  (or as a  utcome or birth 2 gnant at t nown	cler consequ consequ consequ f pregnai Fetal ime of de	ence of):  Hence of):	□ Ectopic p □ Other (sp. underlying c	Dise Dise or dying,  Dise or dying,  Dise or dying,  Dise or dying,	ase. in Part I.  26. Place of i	Death (ing Home	23e. Did 1 □ 24a. Wasa auto perfi 1 □ Yes Check only 5 5 ₹ Res	tobacco Yes 2 san psy prmed? 2 X Noone) idence	Mo use conf □ No 24b.	tribute to 1  3  Pro  Were auturprior to codeath? 1  Yes	very Day  the cause of bably 4 £ opsy finding ompletion of 2 □ No	Year  Year  Munknow  savailable
Siff CCC there	equentially list coany, leading to limuse. Enter Undeause (Disease or at initiated events esulting in death)  FEMALE: 3b. Was deceden in the past 12 1   Yes 2   9   Unknown art III. Other signification of the coange of the coa	Inditions, inmediate rilying injury state to medicate	ions con	Due to  Due to  Due to  Due to  Due to  Due to  Atherete to the total tributing to de to the total tributing to de to the total tributing to de total tributing tributing total tributing tributing total tributing trib	each line eros (or as a (or as a  (or as a  utcome or birth 2 gnant at t nown	cler consequ consequ consequ f pregnal Fetal ime of de	ence of):  Hence o	□ Ectopic p □ Other (sp. underlying c	oregnancy pecify)  cause given  22  DA Other: 28c. Injury a Work?	ase in Part I.  26. Place of 4 Nursinat	Death (ing Home	23e. Did 1 □ 24a. Wasa perfi 1 □ Yes Check only	tobacco Yes 2 san psy prmed? 2 X Noone) idence	Mo use conf □ No 24b.	tribute to 1  3  Pro  Were auturprior to codeath? 1  Yes	very Day  the cause of bably 4 £ opsy finding ompletion of 2 □ No	Year  Year  Munknow  savailable
Siff CCC there	equentially list co any, leading to im ause. Chier Unde ause (Disease or at initiated events soulding in the past 12 1 9 Unknown art II. Other signification of the past 12 1 Yes 2 9 Unknown art II. Other signification of the past 12 1 Yes 2 1 Yes 3 Yes	Inditions, inmediate rilying injury state to medicate	ions con rive	Due to	each line eros (or as a (or as a (or as a  utcome o birth 2 gnant at t nown death but	cler consequ consequ consequ f pregnaine of de not resu  (Year)	rotic lence of): lence	□ Ectopic p □ Other (sp	oregnancy pecify)  ause given  ause given  Contact Injury a Work?  1 □ Ye	ase. in Part I.  26. Place of i	Death (dag Homes 28)	23e. Did 1 □ 24a. Wasa auto perfi 1 □ Yes Check only 5 5 ₹ Res	tobacco Yes 2 an psy prmed? 2 Moone) idence how inju	Mo use confi □ No 24b.  6 □ Otherry occurrent Number	tribute to 1 3 Pro Were autoprior to codeath? 1 Yes	very Day the cause of bably 4 groups finding ompletion of 2 \( \subseteq No. \)	Year  Year  Year  Year  Year  A Unknow  A available avai
Siff ocCuthers	equentially list co any, leading to limuse. Enter Under ause (Disease or act initiated events soulding in the past 12 1   Yes 2   Yes   Ye	Inditions, mediate erlying injury shart to The months?  In the months months months months?  In the months	ions con rive	Due to	each line eros (or as a  (or as a  (or as a  (or as a  intcome or birth 2 gnant at the common of the	cler consequ consequ consequ consequ f pregnal Fetal ime of do not resu  t 2     (Year) y - At ho (Specify	rotic lence of): lence	Heart    Ectopic p   Other (sp underlying c	Dise  Dise  Dregnancy  Drectfy)  Da Other:  28c. Injury a  Work?  1 □ Ye  y, office	ase.  in Part I.  26. Place of 4 Nursin at es 2 No	Death (ag Home 28)	23e. Did  1 □  24a. Was auto perfi 1 □ Yes  Check only  5 ☑ Res  d. Describe	tobacco Yes 2 san psy 2 Noone) idence how inju (Street al wn, State	use conf	onth  3 Pro  Were autoprior to ordeath? 1 Yes  her (Speciated)	very Day the cause obably 4 groupsy finding ompletion of 2 \( \subseteq No \)	Year  Year  Year  Year  Year  Year  A Unknown  as available cause of
Si if co C C th	equentially list co any, leading to imuse. Enter Unde ause. Clisease or at initiated events soulting in death)  FEMALE: 3b. Was deceden in the past 12 1   Yes 2      The Trailure   Yes 2      Hyperte   Diabete      S. Was case refer examiner?   1   Yes 2      T. Manner of Deat   1      T. Matural   2      Accident   3      Suicide   4        Homicide      9a. Certifier (Check only)	Inditions, and the control of the co	ions con rive	Due to	each line eros (or as a (or as a (or as a (or as a  decome o birth 2 gnant at t nown  leath but	cler consequ consequ consequ consequ f pregnal Fetal ime of do not resu  t 2     (Year) y - At ho (Specify	rotic lence of): lence	Heart    Ectopic p   Other (sp. other (sp. other))   Other (sp. other)   Other (sp. ot	Dise  Dise  Dregnancy  Drectfy)  Da Other:  28c. Injury a  Work?  1 □ Ye  y, office	ase in Part I.  26. Place of 4 □ Nursin at es 2 □ No e, date and prion, death of	Death (ag Home 28)	23e. Did  1 □  24a. Was auto perfi 1 □ Yes  Check only  5 ☑ Res  d. Describe	tobacco Yes 2 san psy 2 Moone) idence how inju (Street aawn, State e cause(s, date an	use continued No 24b.  6 Other ry occurrent Number (e)	tribute to 1 3 Pro Were autoprior to occ death? 1 Pro mer (Speciated) ber or Rur anner as and due 1	very Day the cause obably 4 groupsy finding ompletion of 2 \( \subseteq No \) al Route N	Year  Year  Munknowi  Savailable  f cause of
Sift care CC three care care care care care care care c	equentially list co any, leading to lim use. Enter Unde ause. Clisease or carditic very leading to lim the past 12 1 Yes 2 9 Unknown art II. Other signification of the past 12 1 Yes 2 Yes	Inditions, and the control of the co	ions con rive	Due to	each line eros (or as a (or as a (or as a (or as a  decome o birth 2 gnant at t nown  leath but	cler consequ consequ consequ consequ f pregnal Fetal ime of do not resu  t 2     (Year) y - At ho (Specify	rotic lence of): lence	Heart    Ectopic p   Other (sp   other (sp	oregnancy pecify)  Day  Day  Day  Other: 28c. Injury e Work? 1 □ Ye y, office	ase.  in Part I.  26. Place of the set of th	Death (ag Home 28)	23e. Did  1 □  24a. Was auto perfi 1 □ Yes  Check only  5 ☑ Res  d. Describe	tobacco Yes 2 san psy psy primed? 2 Noone) idence how inju (Street aa wn, State e cause(s, date an	use confined No 24b.  6 Other of No 24b.  6 Other of No 24b.  7 Other of No 24b.  8 Other of No 24b.  9 Other of No 24b.  10 Other of N	onth  3 Pro Were autor prior to codeath? 1 Yes  her (Special red  ber or Run  hanner as and due to the ded (Month, the ded (Mo	very Day  the cause of the cau	Year  Year  Year  Year  Year  A Unknow  gs availablif cause of

State Registrar

Physicia /Medica Examine

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Medical Examinat must be notified at

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and pempletely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760, 65

Baltimore, Maryland 21215-0036

31. Date filed (Month, Day, Year)
DEC 3 0 7

y, Year) 32 Registrar's Signature 3 0 2008



29a. Certifier (Check only one)

29b. Signature and title of

MARIAV

DEC

3 0 2008

31. Date filed (Month, Day,

30. Name and addres

Be Completed by Funeral Director

ည

**Physician** /Medical

**Examiner** 

For State Registrar					Cer	tificate of l	Death		Reg	g. No.	200	8	43:	27
1. Decedent's Name	e (First, Middle, L	Last)						2.	Date of Death Month	Day	Year		Time of D	Death
		IZABETH		WILE	Y			1	DEC.	28,	2008		5:50	A M
la. Facility Name (I			mber)			4b. City, Town, or				4c. C	ounty of Dea			
HOLY 5. Social Security N	CROSS I	OSPITAL Sex	7. Age (In yr	a Imaé hiuéi	h da i i	SILV If Under 1 Year	ER SPRI		Date of Birth			TGOMERY  Birthplace (State or Foreign		
272-36-9  Usual Residence of	094	1□M 2 <b>X</b> F	7. Age (iii yi	. \	rs.	Months Days		in.	(Month, Day, ) EC. 17,	/ea <i>r)</i>	C	ountry)		roreign
0a. State	10b. County		10c. (	City, Town	or Loc	ation						10d. I	nside City	/ Limits
OHIO	BELMO	ONT			PΩ	WHATAN P	OTNT					1	∑ Yes 2	2 □ No
0e. Street and Nur		7112	I		10	10f. Zip Code	01111		100	g. Citize	n of What C	ountry?		
107	UNION ST	Γ.				43	942				U.S	. A .		
1. Marital Status		12. Was Dece Armed Fo	edent Ever in	U.S.	13. W	as Decedent of H Yes, specify Cuba		(Specify	y Yes or No-	14	. Race - Am	erican Ir	ndian,	
1 Never Marri	ied 2 ☐ Married		2 XNo			Tes, specify Cube	Specify:	ierio mia	an, etc.)		Black, Whit	te, etc.		
3 Widowed	4 X Divorced	Year or D				LICO LAN	ороспу.			3	pecify:	BLAC	CK	
(Spec	15. Decedent's cify only highest of	Education grade completed)		1	(Give k	ent's Usual Occup	during most of v	vorking	16	6b. Kind	of Business	/Industr	У	
Elementary/Seco	ndary (0-12)	College (1	I-4or 5+)			O NOT use retired	,			ODA	ATEM A	7 773/7	· <b>N</b> TT TN 4	DT 43
7. Father's Name (	/First Middle La	<u>4</u>				SECRETAR		Jame (F	irst, Middle, Ma	ORN		LUMI	NUM	PLAI
			ET 1257				TO. MOTHER ST	·		aden de	,	TZ TO COO	,	
A. Informant's Na	RTHUR		LLEY	19h	Mailine	Address (Street	and Number or	CLA		City or 7		KETT		
	NA WILEY			ı	03					-			θ)	
0a. Method of Disp		I STOTEK	20b.				VE., TE	TIL LI					Stato	
•						ILIOH (IVallic UI	4	Date	20	JC. Loca	tion - City or	Town. S		
		☐ Removal from	State			ition (Name of atory or other plac	i				tion - City or			
4 Donation	5 ☐ Other (Spec	cify)	State		ŢAN	CEMETER	Y_ JAN				IATAN			н.
4 Donation	5 ☐ Other (Spec	cify)	State I	POWHA	TAN 22. C	CEMETER Name and Addres HAMBERS	Y JAN ss of Facility FUNERAL	. 3 . . HON	,2009 : 1E & CR	POWI EMAT	IATAN CORIUM	POIN	IT, 0	н.
4 Donation  21. Signature of Fu	5 Other (Specineral Service Lic	city) consee Comber	State I	РОШНА 1091	TAN 22. C 5	CEMETER Name and Addres HAMBERS 801 CLEV	Y JAN ss of Facility FUNERAL ELAND A	1. 3, HON	,2009 ME & CR RIVER	POWI EMAT DALI	IATAN CORIUM	POIN ,P.A 207	IT, 0	Н.
4 Donation  21. Signature of Fu  23a. Part 1. Enter the shock, or hea	5 ☐ Other (Special Service Lice)  The disease, or court failure. List on	city) consee Comber	MO(	РОШНА 1091	TAN 22. C 5	CEMETER Name and Addres HAMBERS 801 CLEV	Y JAN ss of Facility FUNERAL ELAND A	1. 3, HON	,2009 ME & CR RIVER	POWI EMAT DALI	IATAN CORIUM	POIN P.A 207	IT, 0	een
21. Signature of Fu 23a. Part 1. Enter the shock, or hea mmediate Cause ( disease or condition	5 Other (Specineral Service Lice)  The disease, or court failure. List on (Final	city) spisee COULU emplication to ly one can e on e	MO( aused the de- ach line.	POWHA 0091 ath. Do no	TAN 22. C 5 ot ente	CEMETER Name and Addres HAMBERS 801 CLEV	Y JAN ss of Facility FUNERAL ELAND A	1. 3, HON	,2009 ME & CR RIVER	POWI EMAT DALI	IATAN CORIUM	POIN P.A 207	IT, 0	een
21. Signature of Fu 23a. Part 1. Enter the shock, or hea disease or condition	5 Other (Specineral Service Lice)  The disease, or court failure. List on (Final	cotty)  copiee  Cumber  implications of c ly one cause on e  Due to (	MO( caused the decach line.  IORESI (or as a conse	POWHA  0091  ath. Do not of the property of th	TAN 22. C 5 ot ente ORY f):	CEMETER Name and Addres HAMBERS 801 CLEV r the mode of dyin	Y JAN ss of Facility FUNERAL ELAND A	1. 3, HON	,2009 ME & CR RIVER	POWI EMAT DALI	IATAN CORIUM	POIN P.A 207	IT, 0	een
21. Signature of Fu 23a. Part 1. Enter the shock, or hea Immediate Cause ( disease or condition resulting in death)	5 Other (Special Property of Control of Cont	egisee  Combinations of color	MOO aused the de ach line. IORESI (or as a conse	POWHA  0091 ath. Do not PIRAT equence of	TAN 22. C 5 ot ente ORY f):	CEMETER Name and Addres HAMBERS 801 CLEV r the mode of dyin	Y JAN ss of Facility FUNERAL ELAND A	1. 3, HON	,2009 ME & CR RIVER	POWI EMAT DALI	IATAN CORIUM	POIN P.A 207	IT, 0	een
23a. Part 1. Enter the shock, or hea immediate Cause (disease or condition resulting in death)  Sequentially list confirm, leading to improve the cause (Disease or Cause (Disease (Dis	5 □ Other (Special Property of the disease, or count failure. List on (Final on mediate rhying limitry)	profese  formulation and color of color	MOO aused the de ach line. IO-RESI (or as a conse	POWHA  0091  PIRAT  equence of  R FIB	TAN 22. C 5 ot ente ORY f):	CEMETER Name and Addres HAMBERS 801 CLEV r the mode of dyin	Y JAN ss of Facility FUNERAL ELAND A	1. 3, HON	,2009 ME & CR RIVER	POWI EMAT DALI	IATAN CORIUM	POIN P.A 207	IT, 0	een
23a. Part 1. Enter It shock, or hea mmediate Cause (disease or condition esulting in death)  Sequentially list cortany, leading to mause. Enter Unde Cause (Disease or hat initiated events	5 □ Other (Special Property of Special Proper	profese  formulation and college of the college of	MOO aused the de ach line. IORESI (or as a conse	POWHA  0091  PIRAT  equence of R FIB  equence of A	TAN 22. C 5 ot ente ORY f): RIL	CEMETER Name and Addres HAMBERS 801 CLEV r the mode of dyin	Y JAN ss of Facility FUNERAL ELAND A	1. 3, HON	,2009 ME & CR RIVER	POWI EMAT DALI	IATAN CORIUM	POIN P.A 207	IT, 0	een
23a. Part 1. Enter It shock, or hea mmediate Cause (disease or condition esulting in death)  Sequentially list cortany, leading to mause. Enter Unde Cause (Disease or hat initiated events	5 □ Other (Special Property of Special Proper	profese  formulation and college of the college of	MOO aused the de ach line. IO-RESI (or as a conse	POWHA  0091  PIRAT  equence of R FIB  equence of A	TAN 22. C 5 ot ente ORY f): RIL	CEMETER Name and Addres HAMBERS 801 CLEV r the mode of dyin	Y JAN ss of Facility FUNERAL ELAND A	1. 3, HON	,2009 ME & CR RIVER	POWI EMAT DALI	IATAN CORIUM	POIN P.A 207	IT, 0	een
4 Donation  21. Signature of Fu  23a. Part 1. Enter ti shock, or hea	5 □ Other (Special Property of Special Proper	profese  formulation and college of the college of	MOO aused the de ach line. IO-RESI (or as a conse	POWHA  0091  PIRAT  equence of R FIB  equence of A	TAN 22. C 5 ot ente ORY f): RIL	CEMETER Name and Addres HAMBERS 801 CLEV r the mode of dyin	Y JAN ss of Facility FUNERAL ELAND A	1. 3, HON	,2009 ME & CR RIVER	POWI EMAT DALI	IATAN CORIUM	POIN P.A 207	IT, 0	een
23a. Part 1. Enter the shock, or head immediate Cause (disease or condition resulting in death)  Sequentially list confiant, leading to impause. Enter Unde Cause (Disease or hat initiated events resulting in death) L	5 □ Other (Special Property of the disease, or contrainer. List on (Final on Inditions, Imediate rhying linjury).	coffy)  consee  complications of to the property of the proper	MO( aused the de  ach line.  IO-RESI  (or as a conse  RICULAR  (or as a conse   KALEMIA  (or as a conse  come of preg	POWHA  0091 ath. Do not provide the provid	TAN 22. C 5 5 oot ente ORY ff: RIL	CEMETER Name and Addres HAMBERS 801 CLEV r the mode of dyin ARREST LATION	Y JAN ss of Facility FUNERAL ELAND A g, such as carc	1. 3, HON	,2009 ME & CR	POWI EMAT DALF	HATAN CORIUM E, MD.	POIN ,P.A 207 Apprinte	IT, 0	een
23a. Part 1. Enter the shock, or head immediate Cause (disease or condition cresulting in death)  Sequentially list containing to make. Enter Under Lause (Disease or hat initiated events esulting in death). In the past 12	5 Other (Special Property of Special Property	b. CARDIDUE to (  Language of the content of the co	MOO aused the de ach line.  IO-RESI (or as a conse RICULAN (or as a conse KALEMIA (or as a conse come of preg birth 2 □ Fe nant at time o	POWHA  0091 ath. Do not present the presen	TAN  22. C  5  5  ORY  RIL  (i)	CEMETER Name and Addres HAMBERS 801 CLEV r the mode of dyin	Y JAN ss of Facility FUNERAL ELAND A g, such as carc	1. 3, HON	,2009 ME & CR	POWI EMAT DALF	IATAN CORIUM	POIN ,P.A 207 Apprinte	37 roximate rval Betweet and De	een
23a. Part1. Enter the shock, or hea immediate Cause (disease or condition resulting in death)  Sequentially list confamilies (Disease or Line Unde Cause (Disease or Line Unde Cause (Disease or Line Unde Cause (Disease Chisease Chisease (Disease Chisease or Line Unde Cause)  FFEMALE:  23b. Was decedent	5 Other (Special Property of the disease, or count failure. List on (Final Indiana Property of the disease). The disease of th	crity)  sorbee  CARDI  Due to (  C. HYPOK  Due to (  23c. If yes, out	MOO aused the de ach line.  IO-RESI (or as a conse RICULAN (or as a conse KALEMIA (or as a conse come of preg birth 2 □ Fe nant at time o	POWHA  0091 ath. Do not present the presen	TAN  22. C  5  5  ORY  RIL  (i)	CEMETER Name and Addres HAMBERS 801 CLEV r the mode of dyin ARREST LATION	Y JAN ss of Facility FUNERAL ELAND A g, such as carc	1. 3, HON	,2009 ME & CR	POWI EMAT DALF	ATAN CORIUM E, MD.	POIN P.A 207 Application	37 roximate rval Betweet and De	een eath
23a. Part 1. Enter the shock, or hea mmediate Cause (disease or condition esulting in death)  Sequentially list containly, leading to manuse. Enter Under Cause (Disease or hat initiated events esulting in death).  FFEMALE:  35b. Was decedent in the past 12 1	5 Other (Special Control of Contr	crity)  sepsee  CARDI Due to (  b. VENTE Due to (  c. HYPOK Due to (  d.  23c. If yes, out 1   Live t 4   Pregr 9   Unkn	MO( aused the de ach line.  IO-RESI (or as a conse a CULAF (or as a conse a co	POWHA  20091 ath. Do not provide the provided the provide	TAN  22. C  5 oot enter  ORY  RIL  (f).	CEMETER Name and Addres HAMBERS 801 CLEV r the mode of dyin ARREST LATION  Ectopic pregnance Other (specify)	Y JAN ss of Facility FUNERAL ELAND A g, such as carc	1. 3, HON	,2009 ME & CR	POWI-	CORIUM C, MD.	POIN , P. A 207 App Inte Ons	37 Troximate roval Betweet and De	een eath
23a. Part1. Enter the shock, or hea immediate Cause (disease or condition resulting in death)  Sequentially list confarm, leading to immediate Cause (part)  Sequentially list confarm, leading to immediate Cause (Disease or condition resulting in death) Library (Disease or condition)  FFEMALE:  23b. Was decedent in the past 12 1   Yes 2 2   9   Unknown	5 Other (Special Control of Contr	crity)  sepsee  CARDI Due to (  b. VENTE Due to (  c. HYPOK Due to (  d.  23c. If yes, out 1   Live t 4   Pregr 9   Unkn	ALEMIA  come of pregords or one or on	POWHA  20091 ath. Do not provide the provided the provide	TAN  22. C  5 oot enter  ORY  RIL  (f).	CEMETER Name and Addres HAMBERS 801 CLEV r the mode of dyin ARREST LATION  Ectopic pregnance Other (specify)	Y JAN ss of Facility FUNERAL ELAND A g, such as carc	1. 3, HON	AE & CR RIVER espiratory arres	POWHEMATION DALF	Date of de Month	POIN , P. A 207 Applied Interval Day of the care	37 Troximate roval Betweet and De	een eath
23a. Part 1. Enter it shock, or hea immediate Cause (disease or condition resulting in death)  Sequentially list cort any, leading to immuse. Enter Under Cause (Disease or hat initiated events esulting in death) L  FFEMALE:  3b. Was decedent in the past 12 1	5 Other (Special Property of Special Property	cify)  reprise  CARDI  Due to (  b. VENTE  Lue to (  C. HYPOK  Due to (  d.   23c. If yes, out  1 □ Live to (  4 □ Pregreg 9 □ Unkn  s contributing to de	ALEMIA  come of pregords or one or on	POWHA  20091 ath. Do not provide the provided the provide	TAN  22. C  5 oot enter  ORY  RIL  (f).	CEMETER Name and Addres HAMBERS 801 CLEV r the mode of dyin ARREST LATION  Ectopic pregnance Other (specify)	Y JAN ss of Facility FUNERAL ELAND A g, such as carc	1. 3, HON	ME & CR RIVER espiratory arres	POWHEMAT DALF	DATAN CORIUM C., MD.  d. Date of de Month  contribute to	POIN , P. A 207 Apple Ap	Yeuse of de:	een eath
23a. Part 1. Enter it shock, or hea immediate Cause (disease or condition resulting in death)  Sequentially list cort any, leading to immuse. Enter Under Cause (Disease or hat initiated events esulting in death) L  FFEMALE:  3b. Was decedent in the past 12 1	5 Other (Special Control of Contr	cify)  reprise  CARDI  Due to (  b. VENTE  Lue to (  C. HYPOK  Due to (  d.   23c. If yes, out  1 □ Live to (  4 □ Pregreg 9 □ Unkn  s contributing to de	ALEMIA  come of pregords or one or on	POWHA  20091 ath. Do not provide the provided the provide	TAN  22. C  5 oot enter  ORY  RIL  (f).	CEMETER Name and Addres HAMBERS 801 CLEV r the mode of dyin ARREST LATION  Ectopic pregnance Other (specify)	Y JAN ss of Facility FUNERAL ELAND A g, such as carc	1. 3, HON	23e. Did toba	POWHEMAT DALF	d. Date of de Month  contribute to No 3 P	POIN POIN POIN POIN Applinte Ons  Politivery Day  Tobably  utopsy ficomplet	Yeuse of deading a violent of caution of cau	een ear ath? nknown
23a. Part 1. Enter It shock, or hea mmediate Cause (disease or condition esulting in death)  Gequentially list cord any, leading to impause. Enter Unde Cause (Disease or hat initiated events esulting in death) I.  FFEMALE: 23b. Was decedent in the past 1 1   Yes 2   9   Unknown eart II. Other signiff CHRON.	5 Other (Special Property of Special Property	cify)  reprise  CARDI  Due to (  b. VENTE  Lue to (  C. HYPOK  Due to (  d.   23c. If yes, out  1 □ Live to (  4 □ Pregreg 9 □ Unkn  s contributing to de	ALEMIA  come of pregords or one or on	POWHA  20091 ath. Do not provide the provided the provide	TAN  22. C  5 oot enter  ORY  RIL  (f).	CEMETER Name and Addres HAMBERS 801 CLEV r the mode of dyin ARREST LATION  Ectopic pregnance Other (specify)	Y JAN ss of Facility FUNERAL ELAND A g, such as carc	HONVE.	23e. Did toba  1 Yes  24a. Was an autopsy performe 1 Yes 25	POWHEMAT DALF	d. Date of de Month  contribute to No 3 P	POIN , P. A 207 Applinte Ons  Plivery Day  o the cal	Yeuse of deading a violent of caution of cau	een ear ath? nknown
23a. Part 1. Enter the shock, or heal immediate Cause (disease or condition resulting in death)  Sequentially list confirm, leading to manuse. Enter Under Cause (Disease or hat initiated events resulting in death) L  IF FEMALE: 23b. Was decedent in the past 12 1	5 Other (Special Property of Control of Cont	coffy)  copiese  Complications of copy one cause one  a. CARDI Due to ( b. VENTE Due to (  c. HYPOK Due to (  d.  23c. If yes, out 1   Livet 9   Unkn  c. CY DISEAS	MO( aused the de ach line.  IO-RESI (or as a conse a CULAF (or as a conse of pregointh 2 Fe nant at time o cown)  eath but not reserved.	POWHA  0091 ath. Do not present the property of the property o	TAN  22. C  5  ot ente  ORY  f):  RIL  5  the unc	CEMETER Name and Addres HAMBERS 801 CLEV r the mode of dyin ARREST LATION  Ectopic pregnance Other (specify)	Y JAN ss of Facility FUNERAL ELAND A g, such as carc	HONVE.	AE & CR RIVER espiratory arres	POWHEMAT DALF	d. Date of de Month  contribute to death? 1   Yes	POIN , P.A 207 Appeinte Ons elivery Day to the cal crobably utopsy ficomplet s 2	Yeuse of deading a violent of caution of cau	een ear ath? nknown
23a. Part 1. Enter the shock, or heal immediate Cause (disease or condition resulting in death)  Sequentially list confiant, leading to immediate Cause. Enter Under Cause. Enter Under Cause. Enter Under Cause in the past 12 in the	5 Other (Special Control of Special Control of Spec	cify)  persee  CARDI Due to ( b. VENTE Log to (  c. HYPOK Due to (  d.   23c. If yes, out 1	MOO caused the de ach line.  IO-RESI (or as a consecutive secutive securive secutive securive	POWHA  0091 ath. Do not present the property of the property o	TAN  22. C  5  ot ente  ORY  f):  RIL  f):	CEMETER Name and Addres HAMBERS 801 CLEV r the mode of dyin ARREST LATION  Ectopic pregnance Other (specify)  derlying cause give	Y JAN ss of Facility FUNERAL ELAND A g, such as carc	Death (Cg Home	23e. Did toba 1 Yes  24a. Was an autopsy performe 1 Yes 25 theck only one) 5 Resident	POWE EMATE DALE of the control of th	d. Date of de Month  contribute to death? 1 □ Yes	POIN , P.A 207 Appeinte Ons elivery Day to the cal crobably utopsy ficomplet s 2	Yeuse of deading a violent of caution of cau	een ear ath? hknown
23a. Part 1. Enter the shock, or heal immediate Cause (disease or condition resulting in death)  Sequentially list confirm, leading to manuse. Enter Under Cause (Disease or hat initiated events resulting in death) L  IF FEMALE: 23b. Was decedent in the past 12 1	5 Other (Special Control of Special Control of Spec	coffy)  reprise   CARDI Due to ( b. VENTF Lue to (  C. HYPOK Due to (  d.   23c. If yes, out 1 □ lue to (  d.   23c. If yes, out 1 □ lue to (  Due	MOO caused the de ach line.  IO-RESI (or as a conse RICULAF (or as a conse KALEMIA (or as a conse come of preg birth 2 Fe mant at time o cown eath but not re SE	POWHA  0091 ath. Do not provide the provided death of death provided death of death	TAN  22. C  5  ot ente  ORY  f):  RIL  f):	CEMETER Name and Addres HAMBERS 801 CLEV r the mode of dyin ARREST LATION  Ectopic pregnance Other (specify)  derlying cause give	Y JAN ss of Facility FUNERAL ELAND A g, such as carc	Death (Cg Home	AE & CR RIVER espiratory arres	POWE EMATE DALE of the control of th	d. Date of de Month  contribute to death? 1 □ Yes	POIN , P.A 207 Appeinte Ons elivery Day to the cal probably utopsy fit completes 2	Yeuse of deading a violent of caution of cau	een ear ath? nknown

Medical Certification: To Be Completed by Physician/Medical Examiner

/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and a completely filled in by the funeral director, page 2 should be detached for use as the burla-transit

State Registrar s of person who completed cause of death (Item 23a) (Type, Print) TAYAG, 1500 M.D. Year)

FOREST GLEN RD., SILVER SPRING, MD. . Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D63579

29d. Date signed (Month, Day, Year)

DEC. 28, 2008

20910

all Weathers		State of Maryland /   1-For State Registrar	Department of Certificate of		Reg		08 432
Physici Nedical Exam		Decedent's Name (First, Middle, Last)     GATL P • WEA	ATHERS		2. Date of Death Month December 2	Day Year	3. Time of Death 1050 hrs
		4a. Facility Name (if not institution, give street and number) 3303 Altair Lane		b. City, Town, or Location of Death Upper Marlboro		4c. County of Deat Prince Georg	
Funeral Director		5. Social Security Number 6. Sex 7. Age (	(In yrs. last birthday) 70 Yrs.	If Under 1 Year If Under 24Hrs Months Days Hours Min		(MM/DD/YYYY) 9, Bi Forei	
any		Usual Residence of Decedent  10a. State 10b. County 11	0c. City, Town or Location	on			10d. Inside City Limits
* .	ř	MD. PRINCE GEORGES	U	PPER MARLBORO			1 XYes 2 No
Maryland 28a-f show d at once,	Director	10e. Street and Number		10f. Zip Code	109	g. Citizen of What Cou	untry?
th the M 23a or 2		3303 ALTAIR LANE	148 14	20774		U.S.	
er death wi	Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 X Divorced If Yes, Give Year	X No	s Decedent of Hispanic Origin? (Ses, specify Cuban, Mexican, Puerto  Yes 2 X No specify:		White, etc.	rican Indian, Black,
ours afi atural'	d by	15. Decedent's Education (Specify only highest grade compl	leted) 16a. Decedent	's Usual Occupation (Give kind of		16b. Kind of Business	
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene 27 is marked other than "natural", or items 23a or 28a-f she matic event, the Medical Examiner must be notified at once	Completed	Elementary/Secondary (0-12)  College (1-4 or 5+	o) during mo	ost of working life. DO NOT use ref		PUBLIC	SCHOOL
21215-00; and be filed with Mental Hygiene marked other t	Φ	17. Father's Name (First, Middle, Last)  TROUPE LEWIS			e (First, Middle, Ma HELMA	aiden Surname) ALLEN	
212 ould be d Ment s mark	To B	19a. Informant's Name/Relationship (Type, Print )		Address (Street and Number or			e, Zip Code)
		RITA McNAIR/SISTER		WENDOVER DR.,	FORESTVII	LLE, MD. 2 20c. Location - City of	0747
Baltimore, MD Z permit. Pages I and 2 shou Department of Health and N Important: If item 27 is njury or other traumatic		20a. Method of Disposition  1 Burial 2 X Cremation 3 Removal from State				,	r rown, State
Baltimc permit: Page Department Important:		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee		CREMATORY 12-	-29 <b>-</b> 2008	RIVERDAL	E, MD.
		11/1/11/11/11/11/11/11/11	MO0091 CH	ame and Address of Facility AMBERS FUNERAL I O1 CLEVELAND AVI	HOME & CH	REMATORIUM RDALE, MD.	PA 20737
Physician /Medical xaminer		failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Atherosclerotic C  Due to (or as a conseq	ardiovascular Dise	4.1			Between Onset and Death
	<u>.</u>	Sequentially list conditions, if any, leading to immediate b.  Due to (or as a conseq	uuonoo of):				
P ed 9	Examiner	C.  Due to (or as a consequence events resulting in death) Last  Due to (or as a consequence events resulting in death) Last					
so, te be executed sysician and burial - transit	Medical I	d. UNPENDED AMENDED					
Ox 6876 eath certifica attending ph	sician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1	2 Fet	tal death 3 Ectopic pregn	ancy	23d. Date of delive Month	ry Day Year
P.O. B es that the d igned by the	by Phy	Part II. Other significant conditions contributing to death to	out not resulting in the u	nderlying cause given in Part I.		pacco use contribute to 2 ✓ No 3 Pro	o the cause of death?
of Vital Records, Pig Physician: The law requires I then this certificate has been sign neral director, page 2 should be c	Completed				24a. Was ar autops perforn 1 Yes 2	y prior to ned? death?	outopsy findings available completion of cause of
Vital Rec systeian: The this certificate director, page	Be C	25. Was case referred to medical examiner?		26.Place of Death (Check			
FVIT Physici rthis c	일	1 ✓ Yes 2 No			·	Residence 6 🗸 Othe	er: Scene
Sion of Attending Ph r death. rector: After t by the funeral		27. Manner of Death  1 V Natural 5 Pending  28a. Date of Injury (Month, Day,Yea	/ 28b. Time of Ir	njury 28c. Injury at Work?	280. Describe no	ow injury occurred	
Division Spital or Attendihours after death. Interal Director: /	Certification:	2 Accident Investigation	ry - At home, farm, stree	et, factory, office building, etc.	28f. Location (St or Town, Sta		tural Route Number, City
the ple	Medical C	2ga. Certifier (Check only one) Certifying Physician: To the best of my lone) Physician: To the best of my lone Medical Examiner: On the basis of examiner:					
To With	Me	29b. Signature and title of certifier	. = =	29c. License number		29d. Date signed (M	onth, Day, Year)
5		Mayonie Pheiskule	oth (Hom 22-)	O.C.M.E.		December 25, 2	2008
		<ol> <li>Name and address of person who completed cause of dea Margarita Korell MD. Assistant Medical E</li> </ol>		enn Street, Baltimore, MD	21201		
	tate	31. Date filed (Month, Day, Year) Registrar's	A ST. Company of the St.	6)			
Regis	trar	DEC 3 0 2008	In labour				

3

State of Maryland / Department of Health and Mental Hygiene 43274 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 12/24/2008 **Physician** Janice E. Williams 6:15 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 12237 Meadow Drive Berlin Worcester If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Davs | Hours | Min. | (Month, Day, Year) 7. Age (In yrs. last birthday)
62 Yrs. Birthplace (State or Foreign Country) 5. Social Security Number Funeral 1 □ M 2 X F 219-48-9749 9/14/1946 Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Experience next be notlined at Director 1 □Yes 2 No MD Worcester Berlin 10e. Street and Number 10f. Zin Code 10g, Citizen of What Country? filed within 72 hours after death with Hygiene. 12237 Meadow Drive 21811 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: Specify: White <u>Ş</u> 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Executive Assistant Publishing Co. h and Mental Hygier 7 is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Melvin Ralph Horm Aileen Webster 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health a Chrystal Cottrill/Daughter 100 Cypress Court, Venetia, PA. 15367 permit. Pages 1 and Department of Heal Important: If item 2 any Injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Cape Henlopen Crem. 12/26/2008 Frankford, DE 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility Burbage Funeral Home 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** FUERAL YRS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Electron or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician; The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): attending physician for use as the burial Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) P.0. the 9 ☐ Unknown ģ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an cate has l page 2 s autopsy performed certificate 1 ☐ Yes 2 ☐ No 1 □Yes 2 No 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Soyes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral ( 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 Pending investigation n 24 hours after death.

ne Funeral Director: A
bletely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ٥ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BA5 DOPOTHY ZINOZTH 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

**Physician** /Medical Examiner

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evaminar must be notified at once.

3altimore, Maryland 21215-0036

**Physician** /Medical **Examiner** 

To the Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-tran P.O. Box 68760, Division of Vital Records,

ours after death. eral Director: After this certificate has lefted in by the funeral director, page 2 s within 24 hours a

To the Funeral I

completely filled

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2008 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month 24,2008 11:00P. Eugene D. Zook December 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery General Hospital 01nev Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month Day, Year, Aug. 11, 1927 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Min. 1√2 M 2□F Months Hours Virginia 216-22-1179 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Maryland Prince George's Beltsville Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20705 United States 12200 Myrtle Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1X Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc 1 □ Never Married 2 □ Married 1 □Yes 2□No If Yes, Give Year or Dates: WWII Specify: Specify: White þ 3X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Plaster Painter University of Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Myrtle Caroline Beahm Oscar J. Zook 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan M. Pesce -daughter 3348 Silverton Lane Chesapeake, Maryland 20732 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State George Washington Cemetery 12/29/2008 Adelphi, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Donald V. Borgwardt Funeral Home, 4400 Powder Mill Road Beltsville, 21. Signature of Funeral Service Licenses Maryland 20705 oral Ja 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final RENIAL ACUTE disease or condition resulting in death) Due to (or as a consequence of): SEPSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner PROSTATE CANCER METASTATIC resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown FAILURE TO THRIVE 24b. Were autopsy findings available prior to completion of cause of death? DEPRESSION 24a. Was an autopsy performed? yes 2 🗷 No 1 □Yes 1 ☐Yes 2 ☐No 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 (npatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 2 Accident 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐Yes 2 ☐No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 23i. 108 MD 00068026 25 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Padmaja Bandi, M.D. 18101 Prince Philip Dr. Olney, Maryland 20832 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

Registrar

DEC 3 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** December 31, 2008 Eugenia Zurita 11:30 A M Maria /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's 46015 North Greens Rest Drive Great Mills If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, June 29 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year) 1949 Months Days Hours 1 □ M 2 🛛 F 59 071-48-4592 Director Equador Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural"; or items 23a or 28a-f show any injury or other traumatic event, It Medical Evanture process. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No St. Mary's Maryland Great Mills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 46015 North Greens Rest Drive 20634 USA Funeral Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 □Yes 2 ☒ No Specify: Equador <u>م</u> Specify. 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Migel Guerra ပ Faviola Rosero 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Raul Edmundo Zurita Husband 46015 North Greens Rest Drive, Great Mill, Md 20634 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield-Echols Cem 01/05/2009 Charlotte Hall, MD re of uneral se Brinsfield, Jr. M00052 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Edward N. Leonardtown, Maryland 20650 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** somach disease or condition /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Erner Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical signed by the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2 X No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No nis certificate has director, page 2 s autopsy 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 ☐ Accident 5 Pending investigation s after death.

I Director: A

id in by the fu death. 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital of within 24 hours af To the Funeral Discompletely filled in 29a. Certifier 🛮 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 40055751 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 09 30. Name and address person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar

Schmidt,

31. Date filed (Mo

all

33 Registrar's Signat

40900 Merchants Lane, Suite 205, Leonardtown, MD

20650

			For State Registrar	State of	Maryla	ınd		artmen ertificat			and M	lental Hy	giene Reg. No. '	2008	43	277
ı	Physici /Medic		1. Decedent's Name (First, Middle,	Last)	f	f,	1 1)					2. Date of De Month	Day	Year O	3. Time of 061	
)	Examir Funeral		4a. Facility Name (If not institution, 213 Shea Road 5. Social Security Number		7. Age (In yr	rs. las	-		hiar 1 Year	Location of Locati		8. Date of Bir (Month, Da	An	ounty of Deatline Arui		or Foreign
	Director show	)r	215-30-2456  Usual Residence of Decedent  10a. State 10b. County	W 20 F	79	City,	Yrs. Town or L					9/29/1	929	Mar	10d. Inside Ci	ity Limits
	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hyglene. Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, It. W. Croll Evan.	Funeral Director	Maryland Anne A  10e. Street and Number  213 Shea Road  11. Marital Status	Arundel			hian	10f. Zip	711_	ispanic Orli	gin? (Spe	ecify Yes or No	US	en of What Co	untry?	- <del>X</del>
215-0036	hours after d atural", or iten	by	1 Never Married 2 Marrie 3 Widowed 4 Divorced	Armed For 1 MYes If Yes, Giv Year or Da	ces? <sup>2 □ No</sup> Ko	ore ar	an 16a. Dece	1 □Yes	2 ∏ No al Occup	Specify:		ecify Yes or No Rican, etc.)		Black, White Specify: Wh	etc. ite	
21	filed within 72 Hygiene. other than "ne ent, In. W. di	e Completed	(Specify only highest Elementary/Secondary (0-12)  17. Father's Name (First, Middle, La	College (1-	4or 5+)		life.	ist/0	se retired	e Mana	ager	ng (First, Middle,	Pri	vate In	-	
Maryland	12 should be filed with and Mental Hygie 7 Is marked other traumatic event, In	To Be	Edward Michael	Ayd				_		Mary and Numbe	Ida er or Rura	Hoffma	nn er, City or	Town, State, Z	üp Code)	
Baltimore, I	Page nent o ant: If ary or		Ursula Ayd/Wife  20a. Method of Disposition  1 Burial 2 M Cremation 3  4 Donation 5 Other (Spe		state		ce of Disp netery, cre as Ci	osition (Nar matory or c	me of other plac OTY	e) 1	2/27	0. 2071 Pate /2008	20c. Loc Edge	water,	lary1an	
Balt Balt	permit. Page Department Important: If any Injury o		21. Signature of Funeral Service Li	Cash omplished states	aused the de	eath.	2	2973 S	olom	ons I	slan	d Rd. I	Edgew	s Funer ater,MI	2103	7 te
1	Physician /Medical Examiner		shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	_a. Er	or as a conse	equif	nce of):	CUI	9						Interval Bet Onset and i	
8760,	Attending Physician: The law requires that the death certificate be executed refeath.  refeath.  ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit.	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enser Underlying Cause (Disease or injury that initiated events resulting in death) Last	с	or as a conse											
.O. Box 6	at the death certific by the attending p tached for use as o	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		irth 2 ☐ Fe ant at time o	etal d	eath 3	□ Ectopic p □ Other <i>(sp</i>		у			2	3d. Date of deli Month		Year
ords, P.	w requires that been signed I should be deta	þ	Part II. Other significant condition	s contributing to de	ath but not re	esulti	ng in the	underlying o	ause giv	en in Part I.		23e. Did t		e contribute to	the cause of cobably 4 🗆 l	
of Vital Records,	lan: The law rtificate has b xtor, page 2 sh	e Completed	25. Was case referred to medical							26 Place	of Death	24a. Was autop perfo	rmed? 2 No	24b. Were au prior to death? 1 ☐ Yes	opsy findings ompletion of c	available ause of
Division of V	uttending Physicis death. ctor: After this cer y the funeral direct	Certification: To Be	examiner?  1	28a. Date of (Mont	h, Day, Year)	2	8b. Time Injury	of 2	28c. Injur Work 1 🗆	er: 4 🗆 Nu	rsing Hor	me 5 Residence 1	dence 6 now injury			
Divi	To the Hospital or Atteno within 24 hours after death To the Funeral Director: completely filled in by the i		4 Homicide determin	ad 28e. Place	of Injury - At ig, etc. (Spe best of my k	nowle	edge, dea	th occurred	at the ti	me, date an	nd place,	City or Tow	vn, State) cause(s)	Number or Ru	stated.	
	To the H within 24 To the Fl complete	Medical	29b Signature and title of certifier	and manr		<b>7</b>		20	a Liaone	0 pumbor			20d Data	signed (Month	Doy Voorl	
9	H OH		30. Name and address of person w	Latin	MAN	<i>()</i>	441	Print)	FE	WSE	- 1+	16HW	Ay !	eenh Jana	Vis Me	12140,
	Sta Registi		31. Date filed (Month, Day, Year)		egistrar's Sig	natur	1. 4	arke	1							

Black, White, etc. Specify: White 16b. Kind of Business/Industry Own Home 18. Mother's Name (First, Middle, Maiden Surname) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10881 Harmel Drive Columbia, MD 21044 20c. Location - City or Town, State Baltimore, MD 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 Approximate Interval Between Onset and Death 23d. Date of delivery Day 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital o within 24 hours aft To the Funeral Di 1 Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Dec. 29, 2008 EG. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20832 m 3416 Olfmhom wound, SUITE Low, centry, gistrar's Signature 31. Date filed (Month, Day, Ye m th, Day, Year)
DEC 3 0 State Registrar DHMH 17 Rev 1/2001 **ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

43278

9:20 A M

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 ☐ Yes 2 No

2008

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney 1 - State Amend#20a, per FHDR, HCHD, eg Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** HARLES ESWARD /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Howard County General Hospital Columbia Howard 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1**X** M 2□ F Yrs 212 36 1923 70 08-31-1938 Tennessee Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State 28a-f shov Item 27 is merked other than "natural", or items 23a or 28a-f show other traumatic event, if a Madical Examinating the modified at 1 ☐ Yes 2 No Director MD Howard Ellicott City 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code 21042 United States 4754 Manor Lane Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify 2 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. Is merked other than 10 Carpenter Self Employed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be filk Department of Health and Mental H Importent: If Item 27 is merked oth any Injury or other traumatic even Be Grace Anderson Fred Anderson 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4754 Manor Lane Ellicott City, MD 21042 Carol Anderson/Wife 20c. Location - City or Town, State 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 ☐ Removal from State Crest Lawn Mem. Gard. 1-3-2008 Marriottsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPTIC SHOCK Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Se wentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of): Examine the death certificate be executed attending physician and for use as the burial-transit EUMONIA Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Day in the past 12 months? 5 ☐ Other (specify) 4 Pregnant at time of death n signed by the a d be detached fo 1 ☐Yes 2 ☐ No P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, 2 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 ☑No 24a. Was an has autopsy 1 ☐ Yes 2 12 No completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 🖪 No 1 Yes 1 npatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manuar of Death . Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred e Hospital or Attending P 24 hours efter death. e Funerei Director: After t After Division 5 Pending investigation 1 V Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours e Funerel 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death-occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) GEH, Mg) KENNE 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 14 SuitE 300 ARMORY 32. R gistrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** December 21 2008 7:13 a. M Elihu Samuel Abbott /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Chesapeake Woods Center Cambridge Dorchester 8. Date of Birth
(Month, Pay, Year)
July 14, 1929 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday **Funeral** Days Hours 1 XM 2 □ F Mary land 218-24-5756 79 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits or 28a-f show be notified at 10a State 10b. County Crapo MD Dorchester 1 ☐ Yes 2 X No than "natural", or Items 23a or 28a-f sl he Medical Examiner must be notified Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3240 Robbins Road 21626 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 to Yes 2 □ No If Yes, Give Year or Dates: 1960–89 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2√€ No Specify Specify: white þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Department of Health and Mental Hygien Important: If item 27 is marked other than any injury or other traumatic events. the waterman seafood 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Arthur Theodore Abbott Inez North 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) wife 3240 Robbins Road, Crapo, MD Doris M. Abbott Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 12/23/08 4 □ Donation 5 □ Other (Specify) Sandy Island Cemetery Robbins, MD 22. Name and Address of Facility Thomas Funeral Home P.A. 21. Signature of Funeral Service Licensee )C. JJ 700 Locust St., Cambridge, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eacl, line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** nears disease or condition resulting in death) /Medical ue to or as a consequence Examiner Ulans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine requires that the death certificate be executed attending physician and for use as the burial-transit EANS Box 68760. Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death 9□Unknown 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown the signed by t t be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed Yes 2 certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 2 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 🔲 Yes 1 Inpatient After this 27. Manner of Death 28a. Date of Injury (Month, Day 28h Time of 28d. Describe how injury occurred Certification: 5 Pending investigation To the nospies.

Within 24 hours after death.

To the Funeral Director: Aft 1 ☐ Yes 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

P.0. Division or Vital Records, the Hospital or Attending

> State Registrar

Medical

mowler 31. Date filed (Month, Day, Year)

29b. Signature and title of certiff

29a. Certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

610

Duschmans

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 3:48 P<sup>M</sup> 17 2008 JOHN WESLEY ADAMS, JR. DEC /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Months 1 1 M 2 □ F Hours 218-30-22 Director t. 16, Wash Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it is Modical Examiner must be retified at angle. 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 XYes 2 □ No Urlock 10e. Street and Number 10g. Citizen of What Country? 2/64 U 5 A 12. Was Decedent Ever in U.S.
Armed Forces?

1 XYes 2 No 9 50 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Yes 2 ☐ I If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No ģ 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Be dams Bracke ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hurlock heresa 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 115/09 ington Centery: 1/13/09 / 22. Name and Address of Facility Henry Funeral Home, P.A 510 Washington St. Cank 4 Donation 5 Dother (Specify) Washington, D.C. 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** CHRONIC LYMPHOCYTIC LYMPHOMA disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ď 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 □Yes 2 √ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) After t 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 ☐ Pending investigation I Director: A 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after dea
To the Funeral Director
completely filled in by th 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

Division of Vital Records, P.O. Box 68760,

State

MICHAEL R. BAYDARIAN 31. Date filed (Month, Day, Year) 32. Re

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



BETHESDA MD 20889-5600

01055104A (IN)

NATIONAL NAVAL MEDICAL CENTER

DEC 18 ,2008

Registrar

Division or Vital Records, P.O. Box 68760 the Hospital or Attending Physician: e Funeral

**Physician** 

/Medical

Examiner

**Funeral** 

Director

filed within 72 hours after death with the Maryland r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at **Funeral Director** 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Completed by 3 Widowed 4 ☐ Divorced Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If Nem 27 is marked other t any Injury or other traumatic event, th 17. Father's Name (First, Middle, Last) Be Stanley L. Brittain 19a. Informant's Name/Relationship (Type. Print) Joan Carolyn Birckhead Kimmell 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine attending physician and for use as the burial-tran Physician/Medical IF FEMALE: 23b. Was decedent pregnant signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Be Completed page 25. Was case referred to medical examiner? funeral director. P 1 Yes 2√ No 27. Manner of Death Certification: Natural 2 Accident 3□ Suicide 4 ☐ Homicide 29a. Certifier Medical within 2 To the 29b. Signature and title of certifier 20060638 12/29/2008 MD MD N. Herdono 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tara Mendonca MD

110 HOSPITAI ROAD # 310 PRINCE FREDERICUL 20678 31. Date filed (Month, Day Year) 32. Registra s Signature State 3 2008 0 Registrar **ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician December 2008 Mervyn Amor 0054 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville Montgomery Shady Grove Adventist Hospital Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Year) Nov 6. 1918 India Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location Ontario Department of Health and Mental Hygiene. Important: or Items 23a or 28a-f show important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, its Modical Examinatment 1 Yes 2 No Director Canada Mississauga Pee1 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number death with L4Y 3Z2 1300 Bloor St. STE2511 Canada Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Yes 2 If Yes, Give Year or Dates: 2 XNo 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼No Specify 2 3 Widowed 4 Divorced Indian Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Engineer Film Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank Vincent Amor Marie Quirine 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) L4Y 3Z2 19a. Informant's Name/Relationship (Type. Print) 1300 Bloor St. STE 2511 Mississauga, ON Canada Estelle Amor/wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State W. Arundel Crematory 12/29/08 Odenton, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licenses Goling Homes Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SSINL bastmintestin /Medical Due to or as a consequence of) Examiner diac Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, cate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 ☐ Yes 2 ▼ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2000 2**/**2 No 1 □ Yes filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA Medical Certification: To after death.

Director: After this 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my opinion, death according to the cause (s) and manner as stated. 29a, Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier ss of person who completed cause of death (Item 23a) (Type, Print) Rockville, Md. State Registrar

State of Maryland / Department of Health and Mental Hygiene 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year Physician 2:00P M Dr. Faye W. Allen 14 2008 December /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1323 Magnolia Ave Annapolis Anne Arundel 8. Date of Birth (Month, Day, July 5 If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year) 1 □ M 2 🗘 F 87 1921 289-12-9100 July Ohiő Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location show 10b. County 10d. Inside City Limits 10a. State d other than "natural", or items 23a or 28a-f sho event, the Medical Examinar must be motified at Yes 2 □ No Director Maryland Anne Arundel Annapolis 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 1323 Magnolia Ave 21403 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the line and injury or other traumatic event. Black, White, etc. 1 ☐ Yes 2 ₹ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No 2 Specify: Black 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th 6+ Physician Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Watson Nora Johnson ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 115) • 19a. Informant's Name/Relationship (Type. Print) Aris T. Allen Jr. (Son) 11824 Brookeville Landing Ct. Mitchellville, 20b. Place of this position (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Memorial Park 12-19-08 Annapolis, Md. Wanname Resease of Eacil Sons Mortuary, P.A. 21. Signature of Funeral Service Licensee 821 West St. Annapolis, Md. 21401 m00483 23a. Part 1. Enter the disease, or complications that coused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** we war /Medical s a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last s (uence of) Examiner Due to (or as a o the death certificate be executed burial-transit and Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a ☐Yes 2 No 9 Unknown 9 Unknown The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ģ 1 🗌 Yes 2 No 3 Probably 4 Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificate has I lirector, page 2 s autopsy performed? 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of Certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anna. 2002 Medical 32. Registrar's Signature 31. Date filed (Month, Day, Year) State DEC 1 9 2008 Registrar

AN DEKSON, MARJORIE Marvland 21215-0036

			Pleas	e Type or l			delible Ink aparentoi i					
			1 - State Registrar			Ce	rtificate of	Death		Reg. N	10. 20C	8 4328
	Dhysisi	an	1. Decedent's Name (First, Middle,	Last)					2. Date of Month		ay 20,1	8 3. Time SDE th8
	Physici /Medi		MARJORIE C.	ANDERS	SON				3	mbe	r 1 200	08 10:20PM
	Examir	ier	4a. Facility Name (If not institution,					r Location of Dea	th		c. County of De	
1		_	DOCTORS COMMUNI  5. Social Security Number	TY HOSP	TAL 7. Age (In yrs.	last hirthday)	LANHAN If Under 1 Year	1 If Under 24 Hrs	8 Date of		RINCE G	LORGE 5 sirthplace (State or Foreign
	Funeral Director		577-44-4142 Usual Residence of Decedent	1 □ M 2 🖾 F	75	Yrs.	Months Days	Hours Min		Day, Yea 193	2 Wa	shington, DC
	yland		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation					10d. Inside City Limits
	a-fsh	ctor	Maryland Prince	George's	Lar	nham						1¥⊡Yes 2□No
	or 28	Dire	10e. Street and Number				10f. Zip Code			10g. C	Citizen of What (	Country?
	ath w	<u>a</u>	8919 Hickory Hil				2070				ted Sta	
9	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Madical Expuritment unstite rectified at	Funeral Director	11. Marital Status 1  Never Married 2  Marrie	Armed Fo	2 🗌 No		Was Decedent of H If Yes, specify Cuba 1 □Yes 2⊋ No	dispanic Origin? ( an, Mexican, Pue Specify:	Specify Yes or to Rican, etc.)	No-	Black, Wh	
003	iours iral",	d by	3 Nidowed 4 Divorced	Year or D	ates:		21				Specify: B1	
21215-0036	"natu	Completed	15. Decedent's (Specify only highest	Education grade completed)		(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of we	orking	16b.	Kind of Busines	s/Industry
12	withir iene. than	dmo	Elementary/Secondary (0-12)	College (1	-4or 5+)		erv Atte	•		l D	rivate	
	il Hygi other ent,	BeC	17. Father's Name (First, Middle, La	ast)		MILS	ELY_ALLE	18. Mother's Na	me (First, Midd			
Maryland	should be f and Mental s marked o umatic eve	To E	Sherwood Linkins	3				Arnett	a Ross			
lar)	2 sho and is ma		19a. Informant's Name/Relationshi			1	ng Address (Street					
	1 and 2 Health em 27 i		Francis C. Rusti	in / Cous			Allendal					
Baltimore,	0 0		20a. Method of Disposition 1   Burial 2 □ Cremation 3	B ☐ Removal from	State 20b. F	Place of Dispo cemetery, crei	sition (Name of natory or other plac	:	Date		Location - City o	
蕇	permit. Pag Department Important: I any injury o		4 □ Donation 5 □ Other (Spe	<i>f</i>	Fo		coln Cem.		3/2008		The second secon	Maryland
Ba	permit. Departn Importa any inju		21. Signature of Funeral Service Li	edisee	401118		2. Name and Addre		-			1and 20747
			23a. Part 1. Enter the disease, or c	omplications that c	aused the deat						ic, mary	Approximate Interval Between
4	Physician		shock, or heart failure. Kist of Immediate Cause (Final		5.4	0100 50	1.10					Onset and Death
	/Medical		disease or condition resulting in death)		or as a conseq	uence of):	ilure					l hour
	Examiner		Sequentially list conditions	A5/	Term	inal As	spiration					12/hours
	pe tis	iner	Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events		ن هه م نناهون						,	230 Minute
oly	ficate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death) Last	C	ricula:		llation					Zhours
68760,	s be e sician buria			54010 (	0, 40 4 00,000	140/100 01).						
687	tificate ig phys as the	edic		d				-				
Вох	attending for use a	M/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out			Je				23d. Date of d	elivery
О. В	Physician: The law requires that the death certificate be this certificate has been signed by the attending physicia at director, page 2 should be detached for use as the burn	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 🔼 No		oirth 2 ☐ Feta nant at time of o		Dectopic pregnance Other (specify)			- 1	Month	Day Year
P.	that the de ned by the	Phy	9 Unknown									
Ś	res th signed		Part II. Other significant condition  Par Kinson's			ulting in the u	nderlying cause giv	en in Part I.				to the cause of death?
Ö	w requires to been signer should be to	eted	141 1/1/2014 3	()/50	100				-		2 1 10 3 1	Probably 4 Unknown
of Vital Records,	has l	Completed by							24a, W	as an topsy rformed?	24b. Were a prior to death?	autopsy findings available completion of cause of
ā	iclan: The L certificate ha ector, page 3	မ လ	25. Was case referred to medical						1 □ Ye:	2 2		s 2 🖺 No
Š	ysiclan: nis certific director,	To Be	examiner? 1 ☑ Ves 2 ☐ No	Hospital:	npatient 2	ER/Outpatier	oth 3 DOA Oth	er: 4 Nursing			6 □ Other (St	and the second
5	ding Phys h. After this funeral di	n:T	27. Manner of Death	28a. Date		28b. Time of			28d. Describ			еспу)
ö	Attending or death. ector: After by the funer	atic	1 Natural 5 Pending 2 Accident investiga	tion	n, bay, roan	injury		Yes 2 □ No				
Division	or Att after de Directe I in by t	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ed 28e. Place buildii	of Injury - At heng, etc. <i>(Speci</i>	ome, farm, str fy)	eet, factory, office		28f. Location City or 1	(Street a own, Sta	and Number or i te)	Rural Route Number,
_	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical C	29a. Certifier (Check only one) 2 Medical E.	Physician: To the xaminer: On the b	asis of examina	owledge, deat ation and/or in	h occurred at the ti vestigation, in my o	me, date and place	e, and due to t curred at the tim	he cause ie, date a	(s) and manner nd place, and di	as stated. ue to the cause(s)
	To the within 2	Mec	29b. Signature and title of certifier	and make	ner stated.		29c. Licens	e number		29d. D	ate signed (Moi	nth, Dav. Year)
	⊢ ≶ <del>-</del> ŏ		15/1	1.1/	//	40		06329	6		_	
	\		30. Name and address of person w	ho completed caus	e of death (Iter	m 23a) (Type,	Print)	レンムー	0	/	- 1-	
_				Michae		8118	Good L	uck Ri	La	Sha	m, MD	20706
	Sta		31. Date filed (Month, Day, Year)		egistrar's Signa	dans					,	
	Registr	ar	JAN 1 2 2009	Lever	J.	A and						

			for State Registrar	State of Marylan			te of D		vicinarity	Reg. No	.20	08	43286
	Physicia /Medic		1. Degedent's Name (First, Middle, Last)	- BRET	VTLI	NGI	EN_		2. Date of De Month	eath Da	Y C	Years-	3. Time of Death
3	Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City	, Town, or l	Location of Death	1	40	. County	of Death	
- 2			Anne Arundel Medi				napol					Aru	
	Funeral		5. Social Security Number 6. Sex		last birthday) Yrs.	If Unde Months	er 1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D				lace (State or Foreign try)
	Director		236-28-3626 Usual Residence of Decedent	M 2LJF   85	115.				8/30/	1923	3	Wes	t Virginia
	and w		10a. State 10b. County	10c. Cit	y, Town or Lo	ocation						10	Od. Inside City Limits
	f sho	ō	Maryland Anne Aru	ndol		T	othia	n					1 □ Yes 2 No
	28a-	rect	10e. Street and Number	nder			ip Code	11		10a. C	itizen of V	Vhat Coun	trv?
	with Ba or	<b>Funeral Director</b>	270 Janet's Ct.				711			Ü	USA		
	ns 2:	era		2. Was Decedent Ever in U.	S. 13.			spanic Origin? (S n, Mexican, Puert	pecify Yes or No	0-		e - Americ	an Indian,
"	r iter	큔	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☑Yes 2 ☐ No					o Rican, etc.)		Blac	k, White, e	etc.
03	urs a	þ	3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates: W.W	. II	1 ☐ Yes	2 Mo	Specify:			Specify	" Wh	ite
Maryland 21215-0036	be filed within 72 hours after death with the Maryland tal Hygliene. ed other than "natural", or items 23a or 28a-f show event, the Medical Evan har must be notified at	Completed	15. Decedent's Educ (Specify only highest grade	ation	16a. Dece	dent's Usi	ual Occupa	tion uring most of wor	kina	16b.	Kind of Bu	usiness/Inc	lustry
21	thin 7 e. an "r		Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT	use retired)	anny most or wor	King				
21	filed withi Hygiene. kther thar	ပ္ပြဲ	12th		Busi	ness	Owne			<u> </u>		ar Was	sh
p	2 should be filed and Mental Hygi is marked other aumatic event,	Be	17. Father's Name (First, Middle, Last)					18. Mother's Nan					
<u>y</u> la	2 should be fi and Mental h is marked ot aumatic ever	၉	Herbert C. Br		T				irginia				
Лаг	d 2 should th and Mer 7 is marke traumatic		19a. Informant's Name/Relationship (Type					nd Number or Ru				-	Code)
6	and eath		Cathey Kazanarakis					e., Deal	e, Mary			751 City <i>o</i> r To	um Ctata
0	ges 1 It of H If iter or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☒ R	emovai irom State I	Place of Dispo cemetery, crea					20C. L	ocation -	City or 10	wn, State
Ë	nit. Pagartmen ortant: Injury		4 ☐ Donation 5 ☐ Other (Specify)	Men	orial							I111:	
Baltimore,	permit. Pages 'Department of Important: If ite any Injury or of once.		21. Signature of Funeral Service License	e				s of Facility Ge	_				
	40 = 0 G		more and					ons Isla			ewate	er, M	Approximate
			23a. Part 1. Enter the disease, or complishock, or heart failure. List only or	e cause on each line.	n. Do not en	AD.	ade of dying	c Oh Stru	tor respiratory	Cere.	N/ A4	14.1.	Interval Between Onset and Death
3	Physician		Immediate Cause (Final disease or condition resulting in death)	End 21	age	cu	roug	c On your	or ju		may	viven	- Jeen
	/Medical Examiner		Tooding in about,	Due to (or es a conseq	uerice of):								J
		P	Sequentially list conditions,	. — Due to (or as a conseq	uence of):								
	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events										
<u>,</u>	exect n and al-tra	Exa	resulting in death) Last	Due to (or as a conseq	uence of):				·				
68760,	rificate be executed og physician and as the burial-transit	cal											
.89	- O m	ledical		•									
Вох		N.	23b. was decedent pregnant	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		□ Fatania	pregnancy				23d. Dat	te of delive	ry
	deat	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time of o		Other (s					Мо	nth	Day Year
P.0	that the dended by the detached	Physician/№	9 ☐ Unknown						-				
	The law requires that the death os ate has been signed by the attendi page 2 should be detached for use	by F	Part II. Other significant conditions cor	tributing to death but not res	ulting in the u	ınderlying	cause give	n in Part I.					e cause of death?
Records,	w requires been sign should be								1 🗆	Yes 2	No	3∐ Prob	ably 4 ☐ Unknown
မင	has be	Completed							24a. Was	s an	24b. \	Were auto	psy findings available inpletion of cause of
<u></u>	The I	Įģ.								ormed? 2 Z N	6	death? 1 □ Yes	·
Vital	yslcian: The is certificate director, pag	Be (	25. Was case referred to medical examiner?					26. Place of Dea	th (Check only	one)			
of \	£ £ =	ဥ	1 Yes 2 No	ospital: 1 Inpatient 2				4 LI Nursing H	ome 5 ☐ Res				1)
ū		on:	27. Manner of Death  1 ✓ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Year)	28b. Time o Injury		28c. Injury Work?		28d. Describe	how inju	iry occurr	ed	
sio	at at	cati	2 Accident investigation 3 Suicide 6 Could not be			M		'es 2□No					
Division	l or Attend after death Director: /	Certification:	4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Special	ome, farm, <i>s</i> ti fy)	reet, facto	ry, office		City or To			er or Rura	I Route Number,
	pital burs a eral l		29a. Certifier 1 Certifying Phys	ician: To the best of my kno	wledge deat	th occurre	nd at the tim	e date and place	and due to the	e callee/	e) and m	anner ac c	tated
	To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by th	Medical	(Check only 2 Medical Exami	sician: To the best of my kno ner: On the basis of examina and magner stated.	ation and/or in	nvestigatio	on, in my op	pinion, death occu	irred at the time	, date ar	nd place,	and due to	the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	20-1		25	9c. License	number	.20/	29d.	ate signe	d (Month, i	Day, Year)
			May alt	Planta (	M			1) 214	38	X	1200	emb	n 62008
	4		30 Name and address of person who co	poleted cause of death (Iter	n 23a) (Type,	Print)	2/11	A 1: 1 4	1.10	On	M1	10:00	47
4	HIGH		30 Name and address of person who could be seen and address of person who could be seen as a see	ENTAM YO	t) Da	FENS	st /T	SHWA9	MNITE	UL!	IN !	INY	2/
	Sta	te ar	31. Date filed (Month, Day Year)	32. Registrar's Signa	iture /	1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death December 23 2008 **Physician** 03:26 P M Larkin A. Bauersfeld /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 12/30/1978 Birthplace (State or Foreign
Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Mary Land **Funeral** 1 M 2 F 217-92-1777 29 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10b County 1 ☐ Yes 2 No Director Maryland Anne Arundel Annapolis 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 345 Broadview Lane 21401 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🖾 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 → Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 If Yes. Give Specify: Completed by White 3 ☐ Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Data Entry Specialist St. Anne's Day School 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harry Bauersfeld, III Durant Brooks 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harry Bauersfeld, III/Father 345 Broadview Lane, Annapolis, Maryland 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

21. Signatur Fune el en ce la see Kalas Crematory 12/28/2008 | Edgewater, Maryland 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Road, E shock or heart failure. List only one cause on each line.

23. Part 1. Exer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

29. The such that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. Cause (Final disease or condition) 2973 Solomons Island Road, Edgewater, MD 21037 Onset and Death **Physician** 7/7 eumonic resulting in death) /Medical Due to ( as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Unsacs of Injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of): physician the buria Division of Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) QYes 2 □ No been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ▼No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an s certificate has t lirector, page 2 s autopsy performed 1 ☐ Yes 2 No 1 Yes 2 □No To the Hospital or Attending Physician: within 24 hours liter death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

304

State Registrar addre s of person who completed cause of death (Item 23a) (Type, Print)

12408

12-27-2008

MD

amend line 23a part bPlease Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. aaco hlth dept 12/30/08 dlwState of Maryland / Department of Health and Mental Hygieney 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2/17/2008 **Physician** Edward Burrucker 1443 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Anne Arundel Annapolis 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth
1/17/1922 Birthplace (State or Foreign Country)
 Y **Funeral** 7. Age (In yrs. last birthday) 86 Months Hours Min 1 1 2 M 2 □ F 025-12-7503 Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at MD Anne Arundel Annapolis Director 1 ☐ Yes 🏋 🖺 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 110 Hickory Lane 21403 USA or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1∰Ves 2 No Vietnam Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after renent of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural", or ite 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 White 1 □Yes 2¥Ho If Yes, Give Year or Dates: Specify þ Specify. 3.X.Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Engineman US Navy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Arthur Burrucker Sophie Schwarm 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other trau Son Edward Burrucker Jr. 939 Galesville Rd. Galesville, MD 20765 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2XXCremation 3 ☐ Removal from State Atlantic Crematory 12/20/2008 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Funeral Service Licensee 12 Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 1004 disease or condition resulting in death) /Medical Die to (or as a consequence of) Examiner Pneumonia Sequentially list conditions week Examiner in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (vi as a consequence of) or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burlal-tran resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) P.O. 1 ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 □ Saknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy certificate Division of Vital 2 016 1 ☐ Yes 2 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 hpatient 2 ER/Outpatient 3 DOA Medical Certification: To funeral 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No the f 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and majorer stated. 29a. Certifier completely (Check only one) 29b. Signature and title of 29d. Date signed (Mpnth, Day, Year) 00 cause of death (Item 23%) (Type, Print) 4nwal 31. Date filed (Month State Registrar

ula Baranows		1- For State	State	of Maryl	and / Depa	artment of rtificate of	Health			Hyg	iene Reg.	No. 2	800	4328		
Physici	an/	Registrar 1. Decedent's Name (First	Middle,La	nst)					11		Date of Death			ne of Death		
edical Exami	Alla	Paula J. B	<u>arano</u>	wski				_			Month December 3		Uč	333 hrs		
		4a. Facility Name (if not in Harford Memoria			number)	4	lb. City, Tov Havre c			eath		4c. County of Harford	t Death	72-11-1		
Funeral		Social Security Number			7. Age (In yrs. I	ast birthday)	If Under		If Under 24	Hrs.	B. Date of Birth		9. Birthplace	e (State or Foreign		
Director		216-44-0366	- 1	м 2Х F	60	Yrs	Months	Days		Min.	05/30/		Country) Marys			
		Usual Residence of Dece		IVI 2/1	00	113					03/30/	1740	Much	Saria		
any		10a. State 10b. C	ounty		10c. City	Town or Locati	on							Inside City Limits		
and show nce	5	MD H	arfor	Ld	Н	avre de	Grac	e			10		1 4	Yes 2 No		
Maryl 28a-f d at o	Director	10e. Street and Number					10f. Zip C	ode			10g	. Citizen of Wh	at Country?			
ith the Maryland 23a or 28a-f show any notified at once	ä	300 Woodduc	k Cou	vrt				1078				U.S.A				
th wit ems 2 t be n	Funeral	11. Marital Status 1 Never Married 2	XMarrie		ecedent Ever in U Forces?		s Decedent es, specify (				ify Yes or No- can, etc.)	r No- 14. Race - American Indian, Black,				
er dea	Ē			1 Yes		1	Yes 2X	No	specific			Specify:	tul 1 h			
ırs aft hıral" ımine	l by	15. Decedent's Education		or Dates:		16a. Deceden	t's Usual Od	ccupatio	n (Give kind	of wor	k done 1	WILLE				
72 hou n "nat	etec	Elementary/Secondary			(1-4 or 5+)	during m	ost of working	ng life. D	OO NOT use	retired	1)					
036 ithin ne.	Completed	12					Homem	aker	L =			Home				
5-0 fled w Hygic I othe		17. Father's Name (First,	Middle, Las	st)				18	3.Mother's N		irst, Middle, Ma		)			
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Importment; If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	o Be	Otto B. Jon 19a. Informant's Name/Re	gense	2n		40h Mailin	Addesse	(0)			t Getn		- Ctat- 7:- /	Davida)		
D 2 shoul and N 7 is m	۲				111	114		•				•				
Baltimore, MD overnit Pages 1 and 2 sh Department of Health and Important; If item 27 is injury or other traumat		Carroll J.  20a. Method of Dispositio	<u>barar</u>	<u>iowsri</u>	THUS DANA 20b.	Place of Dispos	ition (Name	of ceme	etery,	<u>αυπ</u>	Date GA	20c, Location -	City or Town	State		
Ore ges 1 it of H it If i		1 Burial 2 X Cre	mation -3	Removal	from State	crematory or ot	ner place)									
Itim it Pa irtmen ortant		4 Donation 5 O 21. Signature of Funeral S			18.	A. Ferri	S & C	ddress c	nc. 0	700	6/20091	West (	Cheste	r. PA		
Department of the partment of						12	3 S	Wash	inata	n S	xman ru troot	Hauro 1	tome,	o MD		
Physician		23a. Part I. Enter the dise	ase, or cor	nplications that	caused the death	n. Do not enter t	ne mode of	dying, si	uch as card	ac or r	espiratory arres	t, shock, or he	art Ap	proximate Interval		
/Medical		failure. List only one Immediate Cause (Final of			sive Atherosc	lerotic Card	iovascula	ar Dise	ase				De	Death		
kaminer		or condition resulting in d			a consequence o											
	<u></u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):  Due to (or as a consequence of):														
	Examiner	cause. Enter Underlying Cause														
ed Isit	Xa	events resulting in death) Last  Due to (or as a consequence of):														
oe executed ician and irial - transit	dical	UNPENDED	1	dAMENDED												
e be e ysicia	ed:											Tool Date of	deliver			
that the death certificate bened by the attending physiderached for use as the bu	Physician/Me	IF FEMALE: 23b. Was decedent pregnate 12 months?	ant in the		s, outcome of preg e birth		etal death	3	Ectopic pr	egnand	у	23d. Date of Month	Day	Year		
Box 6 e death cer the attendi	Sicia	1 Yes 2 No 9	<b>₽</b> Hokoo		gnant at time of d	eath 5 O	her (Specif	fy)				0				
. BC he des	الجُ	Part II. Other significant		J S JOHN	to dooth but not	reculting in the	and orbiting o	auco di	on in Part I	_	23e Did toh	acco use contr	ibute to the c	ause of death?		
ires that the signed by	5	DM	oonamon	Contributing	to death but not	resoluting in the	andenying e	adde gii	voir in r die r			-		4 <b>V</b> Unknown		
ds, equire een sig	Completed	h =====							-	_	24a. Was ar	1 24b. 1	Were autopsy	findings available		
COF law r has b	[ 월									_	autops: perform		prior to compli death?	etion of cause of		
of Vital Records, ag Physician: The law require this certificate has been someral director, page 2 should it		05 14(		1			26	C Diano	of Death (Ch		1 Yes 2	✓ No 1	Yes	2 No		
ital sician s cert	Ba B	25. Was case referred to examiner?		Hospital:	Inpatient 2	ER/Outnatien	process;	10	Mhor:			tesidence 6	Other:			
n of Vi ding Physi After this funeral did	유	1 Yes 2 1 27. Manner of Death	<b>N</b> 0	28a. Da	ite of Injury	28b. Time of			at Work?		8d. Describe ho					
on C arth. rr: Af	lë	1 V. Natural 5	Pending		nth, Day,Year)			1Ye	es 2 No							
Division of Vital Into Hospital or Attending Physician; hin 24 hours after death. The Tenneral Director: After this certifulation by the funeral director,	Certification:	2 Accident 3 Suicide 6	Investiga Could n	28a PI	ace of Injury - At I	nome, farm, stre	et, factory, o	office bu	ilding, etc.	2			er or Rural R	oute Number, City		
Div nital o eurs af eral D	eri:	3 Suicide 6 4 Homicide	determin		fy)						or Town, Sta	ate)				
Hosp 24 ho Fune					est of my knowle											
Do the Hospital within 24 hours To the Funeral completely filled	Medical			ner:On the basi and manne	is of examination r stated.	and/or investiga				red at t	he time, date a					
	Ž	29b. Signature and title of	certifier					License				29d. Date sign		Pay, Year)		
		Tarnets Vi	ithai	1 MD				O.C.N	1.E.			January 2,	2009			
		30. Name and address of					1 Poss (	Stroot	Raltimo	0 1/1	7 21204					
		Pamela E. South 31. Date filed (Month, Da)			nt Medical Exa Registrar's Signa		1 Penn S	oreet,	pailimor	e, IVII						
S Regis			(, year)	32.	. Togratian a digital		Mirror - annual -		Á		see d	Bo	S.O.			

Division or Vital Records, P.O. Box 68760. To the Hospital or Attending Physician: 24 within 2.

> State Registrar

Medical

29a, Certifier

29b. Signatur and title of certific

tun

31. Date filed (Month, Day, Year) DEC 2 9 2008



and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

H51793

29c. License number

29d. Date signed (Month, Day, Year)

12/24/08

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar 43291 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 12:15 PM Lillian Hauck Brady DECEMBER 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Anne Arundel Baltimore Washington Medical Center Glen Burnie If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 □ M 2 🕱 F 80 Months Days Hours 122-20-2052 July 08,1928 Director New York Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any injury or other traumatic excessions. 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location Funeral Director 1 □Yes 2√ No MY Rockville Centre Nassau 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Condo: B-11 11570 USA 120 Morris Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married White 1 ☐Yes 2 X No Specify Completed by 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Salesperson Direct Sales 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Julius Hauck Margaret Mauch 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothea Brugnoli/Daughter 348 Sheffield Road Severna Park, MD 21146 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 19, 1 ☐ Burial 2XI Cremation 3 ☐ Removal from State Atlantic Crematory Glen Burnie, MD 2008 4 ☐ Donation \_ 5 ☐ Other (Specify) 21. Signature of Soneral Service License 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy. Severna Park, MD 21146 23a. Pa 1. Enter the disease, or come ock, or heart failure. List only Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) e7191 Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, any, cause the universal cause. Enter Underlying Cause (Disease or injury that initiated events Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) s been signed by the should be detached 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Records, 4eloma 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown has been 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☒ No 24a. Was an page 2 autopsy performed After this certificate Vital 1 □ Yes 2 □ or Attending Physiclan: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Anpatient Medical Certification: To 2 ER/Outpatient 3 DOA o completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural Division 5 Pending investigation 1 ☐ Yes 2 ☐ No death 2 Accident within 24 hours after deat To the Funeral Director: 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) DO06/219 DECEMBER 18, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL 301 HOSPITAL DRIVE, GLENGURINE

Registrar

State

BWMC

SINGH

ARVINDER

31. Date filed (Month, Day, Year)

DEC 2 3 2008

ARORA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month **Physician** Beverly Jean Barranco December 5:58 a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Hospice Towson If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Hours Months 1 □ M 2 🗙 E Yrs. Director 173-32-6246 April 19, 1936 Pennsylvania Usual Residence of Decedent 10a. State 10c. City. Town or Location 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Director MD Baltimore Lutherville 1 ☐ Yes 2 ☑ No the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 205 Welford Road 21093 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 □ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Health 12 should be filed with and Mental Hygier 7 is marked other the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Chester Dellinger Violet Ferree ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any Injury or other trau Frank T. Barranco, Sr./Husband 205 Welford Road Lutherville, MD 21093 20b. Place of Disposition (Name of cemetery, crematory or other place)
Dulaney Valley
Memorial Gardens 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Dec. 23, 2008 4 Donation 5 Other (Specify) Timonium, MD 21. Sign were of Fiveral Service License 22. Name and Address of Facility Barranco & Sons, 495 Gov. Ritchie Severna Park Funeral Home Severna Park, MD 21146 23a. Pa 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, slock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imm-diate C- use (Final dise se or ondition result in death) **Physician** 6/18/19stoma multitorme MONTHS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and burial-Due to (or as a consequence of) P.O. Box 68760 Physician/Medical the attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) ed by the detached 9 Unknown s been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? Yes 2210 certificate 1 ☐ Yes 2 No 1∏Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 0501 C 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 | Pending death. 2 Accident investigation 1 ☐ Yes 2 ☐ No after death Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide filled in I 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) within 2. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0061199 Dec, 20, 2008

Registrar

Jason Black

31. Date filed (Mon

North Charles St. Suite 209 Touson Mis 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6565

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Year **Physician** CATHERINE HARTMAN BEALL DECEMBER 18, /Medical 2008 4:40 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death GINGER COVE HEALTH CENTER ANNAPOLIS ANNE ARUNDEL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1/28/1923 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Months Min 1 □ M 2 🕅 F 85 Director 578-20-4775 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits irai", or items 23a or 28a-f sho Director 1 ☐ Yes 2 🛣 No Maryland Anne Arundel Annapolis 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 4000 River Crescent Dr. USA 21401 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No White Specify: þ Specify: 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4or 5+) Office Manager Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental h Charles N. Hartman Mildred B. Hardesty ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 Gary L. Beall/ Son 2505 Valley Way, Cheverly, MD 20785 other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State = 5 Department of Important: If any injury or once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5 🗷 9ther (Specify)Entombment Hillcrest Cemetery 12/ 22/08 Annapolis, MD 22. Name and Address of Facility GEORGE P. KALAS FUNERAL HOME 21. Signature propagation and Service Mensee 2973 SOLOMONS ISLAND ROAD, EDGEWATER. 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 73 6 months disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Dav Year 5 Other (specify) Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ page 2 should be Completed 1 🗌 Yes No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performer res 2 1 ☐ Yes 2 🗆 No 1 ☐ Yes filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: ဥ 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? Medical Certification: 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Natural death. 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death e Funeral Director: 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

State

To the within 2

completely

31. Date filed (Month, Day, Year)

4 Homicide

(Check only

29b. Signature and 10e of certifie

29a, Certifier

30. Name and address of person who completed cause death (Item 23a) (Type, Print)
Pavl B. Berez MD 2225E Defense Hwy, Crofton, MO 21114 32. Registrar's Signature

EcrtifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D0029571

Registrar

Physic /Med Exami

**Funera** Directo

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must be notified at apries.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

	1 - State Registrar	Cer	tificate of	Death	Reg. No.								
ion	1. Decedent's Name (First, Middle, Last)				2. Date of De Month	eath Day	Year	3. Time of Death					
ian ical	Rosie Booth				Decemb		2008	0052 M					
ner	4a. Facility Name (If not institution, give street and number)		4b. City, Town, o	Location of Dea	ath	4c. Cou	nty of Death						
	Calvert Memorial Hospital		Prince Fred	lerick		Calve	rt						
0	5. Social Security Number 6. Sex 7. Age (In yrs. last to	birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Mir		rth av Year)	9. Birth	place (State or Foreign intry)					
•	579-46-6644 1 M 2 N F 93	Yrs.	Months Days	Hours Will	July 7, 1		Mary						
	Usual Residence of Decedent												
	10a. State 10b. County 10c. City, To	wn or Loc	cation					10d. Inside City Limits					
흕	MD Calvert Owings	;						1 ☐ Yes 2 No					
Director	10e. Street and Number		10f. Zip Code			10g. Citizen	of What Cou	ntry?					
10	205 Skinners Turn Road			20736		USA							
Funeral	11. Marital Status 12. Was Decedent Ever in U.S.	13. V			Specify Yes or N		Race - Ameri	ican Indian.					
큔	Armed Forces?  1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No	li li	Vas Decedent of F Yes, specify Cuba	an, Mexican, Pue	rto Rican, etc.)	E	Black, White,						
þ	If Yes, Give 3X Widowed 4 □ Divorced Year or Dates:	1	☐Yes 2XINo	Specify:		Spe	ecify:	lack					
P		Sa. Deced	lent's Usual Occup	ation		16b. Kind or							
pled	(Specify only highest grade completed)	(Give I	kind of work done OO NOT use retired	during most of wo	orking								
Completed	Elementary/Secondary (0-12) College (1-4or 5+)	House	-wife			Ov	vn Home	4					
BeC	17. Father's Name (First, Middle, Last)	11000	SWIIC	18. Mother's Na	ame (First, Middle								
	Hoover Hall				D	abal Hall	and						
2		9h Mailin	g Address (Street	and Number or F		achel Holla		in Code)					
								p code,					
	Joyce V. Smith - Niece  20a, Method of Disposition 20b. Place		Peabody Str sition (Name of	eet NVV #3	Date Date	20c. Location		own State					
	1X Burial 2 ☐ Cremation 3 ☐ Removal from State	tery, crem	natory or other place	ce)	Date	200. 2004110	iii Oily Oi i	own, diate					
			Church Cen		2009	Sunderla	and, MD	)					
	21. Signature of Funeral Service Licensee	22	. Name and Addre	ss of Facility									
	V. Slady G. Servel	Sev	vell Funeral Ho	ome, P.A., 14	151 Dares Be	ach Rd., Pr	ince Fred	derick, MD 20678					
	23a. Part 1. Enter the disease, or complications that caused the death. D shock, or heart failure. List only one cause on each line.	o not ente	er the mode of dyin	ng, such as cardi	ac or respiratory	arrest,		Approximate Interval Between					
	Immediate Cause (Final disease or condition	IA						Onset and Death					
	resulting in death)  a. Due to (or as a consequence												
	PULMONAC		Man A										
ĕ	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying  b. PULMOWARY EDEM A  Due to (or as a consequence of):												
Examiner	Cause (Disease or injury												
Exa	that initiated events resulting in death) Last Due to (or as a consequence of):												
/Medical	u.												
N/S	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy					234	Date of deliv	verv					
ciar	in the past 12 months?		Ectopic pregnand Other (specify)	y		Lou.	Month	Day Year					
Physicia	1 Yes 2 No 4 Fregnant at time of deatr	. 0_											
	Part II. Other significant conditions contributing to death but not resulting	in the ur	nderlying cause giv	en in Part I.	23e. Did	tobacco use c	ontribute to	the cause of death?					
Completed by	DEMENTIA, CECAL MASS,	THYR	DID DI	ERSE	1	Yes 2 □ N	o 3 Pro	bably 4000 Onknown					
etec			0.0	-, -	-								
du					- 24a. Wa:	ppsy	prior to co	opsy findings available ompletion of cause of					
S					pen 1 □ Yes	ormed? 2 No	death? 1 ☐ Yes	2 🗆 No					
Be	25. Was case referred to medical examiner?				eath (Check only	one)							
	1 ☐ Yes 2 ☐ Hospital: 1 ☐ Inpatient 2 ☐ ER/	Outpatien	t 3 DOA Oth	er: 4  Nursing	Home 5 ☐ Res	sidence 6 🗆	Other (Spec	ify)					
ä	27. Manner of Death   28a. Date of Injury   28t   1 Natural   5 Pending   (Month, Day, Year)	o. Time of Injury	28c. Inju Wor	ry at k?	28d. Describe	how injury oc	curred						
atic	2 Accident investigation			Yes 2 ☐ No									
₽	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)	farm, stre	eet, factory, office		28f. Location	(Street and Nu	ımber or Rui	ral Route Number,					
Certification: To						,							
cal	29a. Certifier (Check only (Ch	dge, death	n occurred at the ti	me, date and pla	ice, and due to the	e cause(s) and	1 manner as	stated.					
Medical	one) and manner stated.	and/or in	vesagation, in my	opinion, death oc	curred at the tille	, uate and pla	Je, and due	to the cause(s)					
Σ	29b. Signature and title of certifier		29c. Licens		2	29d. Date sig							
	Mexis Willeas,	NO	100	1023	)	121	3110	8					
	30. Name and address of person who completed cause of death (Item 23.	a) (Type,	Print)										
	GLOMS A MODOY, MD 110 HOS			10 PR1	NCE FR	COGNICI	4, 40	20678					
ate	31. Date filed (Month, Day, Year) 32. Registraris Signature						,						
trar	DEC 3 1 2008	B.	March	P									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 27 2008 December Barber AM Robert James 4:42 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince Frederick

| Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick | Frederick Calvert Calvert County Nursing Center 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 X M 2 □ F 89 10-02-1919 293-03-8735 Ohio Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Anne Arundel Deale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6014 Allwine Avenue 20751 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Specify: 3 ₩ Widowed 4 Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 telephone company plant manager telephone 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Louis Barber Helen Rowena Hammond 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert J. Barber, Jr., son 6014 Allwine Avenue, Deale, MD 20751 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 12-29-08 Alexandria, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Obstructive Airway Chyonic disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of): Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Heart 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Renal Insubbluency 2 🗆 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No 27. Manner of Death

**Physician** /Medical Examiner

be execut

Records, P.O. Box 68760,

**Physician** 

Examiner

**Funeral** 

Director

show

Director

Funeral

<u>ک</u>

Completed

Be ၉ MD

7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinat must be notified at

permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "na any Injury or other traumatic event than "na once.

72 hours after death with the Maryland

3altimore, Maryland 21215-0036

/Medical

Examiner Physician/Medical

burial-tran and physician the attending pl for use as t the ģ signed t I be deta ate has page 2 s

þ Completed Be Certification: To

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

funeral director, the upletely filled in by

Division of Vita	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific	
	P ≥ P	

The

State Registrar

Medical

Congestive Diabetes

> Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
> 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

> > 29d. Date signed (Month, Day, Year)

12-27-2008

29c. License number

D 50653

	Ch	U	p~	•	3 00 -		
							_

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

Gyan C. Surana, M.D.,

DEC 3 0

2008

5851 Deale Churchton Road, Deale, MD 20751 31. Date filed (Month, Day, Year) 32. Registrans Signature

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, the Hospital or Attending Physician: after death Director:

> State Registrar

Medical

29a. Certifier

29b. Signature and title of certifier

and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	For State State Registrar	i iviai yiaila / L		tificate of L			eg. No. 20	08	43291		
	Dharaista		1. Decedent's Name (First, Middle, Last)				<del></del>	2. Date of Deat Month		Year	3. Time of Death		
	Physicia /Medic		Wilma Alice Baker					Decembe	er 31,	2008	1:30 P <sup>M</sup>		
	Examin	er	4a. Facility Name (If not institution, give street and nur	nber)		4b. City, Town, or		th	4c. County				
	Eumaral		1277 Dilly Road  5. Social Security Number 6. Sex	7. Age (In yrs. last bir	rthday)	Oakland If Under 1 Year	If Under 24 Hrs	8. Date of Birth	Garr	9. Birthpl	lace (State or Foreign		
	Funeral Director		219-34-7151 1 M 2 TXF	71	Yrs.	Months Days	Hours Min	Jan. 30		Coun: West	try) Virginia		
	and ow		Usual Residence of Decedent  10a, State 10b, County	10c. City, Town	n or Loc	ation				10	Od. Inside City Limits		
	Mary	to	MD Garrett	0ak1a	and						1 ☐ Yes 2 ☐ No		
	or 28g	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of V	Vhat Count	try?		
	23a	ral	1277 Dilly Road			21550			United				
	er de	Funeral	Armed Fo		13. W	as Decedent of H Yes, specify Cuba	ispanic Origin? ( ın, Mexican, Pue	Specify Yes or No- rto Rican, etc.)		e - America ck, White, e			
9000	urs am al", or	þ	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes If Yes, Giv 3 ☐ Widowed 4 ☐ Divorced Year or Di	/e	1	□Yes 2XINo	Specify:		Specify	. Whi	te		
ָרָ ה	permit. Pages 1 and 2 should be lied within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Inmoortant: If time Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Machel Examine 1, ust the notified at once.	Completed	15. Decedent's Education (Specify only highest grade completed)	16a.	. Decede	ent's Usual Occup- ind of work done of O NOT use retired	ation furing most of wo	orking	16b. Kind of Bu	usiness/Ind	lustry		
7	within ene. than t	dwc	Elementary/Secondary (0-12) College (1			o <i>nor use retired</i> maker	"		Own Home				
7 - 2 :	Hygi other ent,	Be C	17. Father's Name (First, Middle, Last)		TOME	ind RC I	18. Mother's Na	me (First, Middle, M					
ישובן	Venta Venta Irked Itlc ev	To B	William Henry Murphy				Lucy A	lice Bown	nan				
9	and I		19a. Informant's Name/Relationship (Type. Print)	19b	. Mailing	Address (Street	and Number or F	Rural Route Number	; City or Town,	State, Zip	Code)		
≥ °	and health im 27 ther tr		Mr. Floyd Baker, Husban			Dilly Ro	-		21550 20c. Location -	City or To	vun Stata		
5	nt of h		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from	state		ition (Name of atory or other plac	, -, -	/2009		-			
	artme ortant injury		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licensee	Garret		emorial ( Name and Addres			0aklan		-		
0	Depar Impol any ir		* Katherini Sure	FIC				Funeral , Oakland					
П			23a. Part1. Enter the disease, or complications that c shock, or heart failure. List only one cause on e	aused the death. Do							Approximate Interval Between		
- P	hysician		Immediate Cause (Final disease or condition	1	2						Onset and Death		
	/Medical examiner		resulting in death)  Due to	r as a minsequence	of):	[ - 1 -	1.1.1	nelive		1	11000		
		ē	Sequentially list conditions,	or as a consequence	ラ <b>へ</b> こ 00.	hitis	1001 to	net ve		- 19 1	year)		
4	ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events		•						J		
,00	nincate be executed ng physician and as the burial-transit		resulting in death) Last Due to (	or as a consequence	of):								
0/0	ohysic the bi	Medical	d							-			
<b>D</b>	oding p	/Me	IF FEMALE: 23c. If yes, out	come of pregnancy					22d Dat	to of dolling			
ם ק	atten d for u	Physician/	in the past 12 months?  1 Ves 24 No.	oirth 2 🗆 Fetal death nant at time of death		Ectopic pregnancy Other (specify)	у			te of delive onth	Day Year		
5	by the	hysi	9 Unknown 9 Unkn	own									
, ,	igned be dei	by P	Part II. Other significant conditions contributing to de	eath but not resulting in	n the un	derlying cause give	en in Part I.		1		e cause of death?		
colds,	lledun s	ted	Tobacco use					1200	es 2 No	3∐ Proba	ably 4 ☐ Unknown		
ט יַּ	has b	Completed						24a. Was a autops perforr	mad?	Were autop prior to con death?	osy findings available appletion of cause of		
ק ק	ifficate		25. Was case referred to medical				00 Pl f D-	1 □Yes	2 <b>4</b> No	1 ☐ Yes	2 🗆 No		
<b>-</b>	ysicia is cert directe	To Be	examiner?	npatient 2 ☐ ER/Oι	utpatient	3 □ DOA Othe		eath (Check only on Home 5 Reside		er (Specifi			
5 å	fter th	T:uc		of Injury 28b.	Time of Injury	28c. Injur Work		28d. Describe ho			<u>/</u>		
מוכו	leath. for: A the fu	catio	2 Accident investigation			M 1 □	Yes 2 □ No						
	after of Direct of In Direct of	Certification:	determined 28e, Place	of Injury - At home, fa ng, etc. <i>(Specify)</i>	irm, stre	et, factory, office		28f. Location (St City or Town	reet and Numb n, State)	er or Hural	Houte Number,		
1	To the hospital or Attentioning Fringstrain. The law requires that the beart set within 24 hours after death.  To the Euneral Director: After this certificate has been signed by the attendit completely filled in by the funeral director, page 2 should be detached for use	Medical C	29a. Certifier (Check only one)  1 CertifyIng Physician: To the beautiful and man	best of my knowledge asis of examination ar ner stated.	e, death nd/or inv	occurred at the tire estigation, in my o	ne, date and pla- pinion, death occ	ce, and due to the courred at the time, d	ause(s) and ma ate and place,	anner as st and due to	ated. the cause(s)		
T.	within To th comp	Me	29b. Signature and title of certifier	1		29c. Licens			9d. Date signe		Day, Year)		
			I Smiel H Smil	kily !	_r		64300		1-2-				
		3	30. Name and address of person who completed caus Daniel Bucking ham	e of dea (Item 23a) 255 N	(Type, F	erint) urth St	reet S	inte 1	Oaklo	and	MD 21550		
H	Sta Registr		JAN - 5 ZHIQ 3	egistrar's Signature	A	and I							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene L3298 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Ye ar **Physician** Ruth B. Brown 2008 DECEMBER /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Washington Hagerstown If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 😾 F Months Maryland 219-64-4989 82 January Director 1926 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, it a Medical Examilism must be notified at 10d. Inside City Limits Director 1 ☐ Yes X☐ No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 5640 Crabapple Drive 21703 U.S.A. death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No If Yes, Give Year or Dates: Specify: 2 Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygis Important: If item 27 is marked other any Injury or other traumatic event, III 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be B. Claytus Brandenburg Leah M. Williams ൧ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard F. Brown - Husband 5640 Crabapple Drive, Frederick, Maryland 21703 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Mt. Olivet Dec. 30, 2008 4 Departion 5 ☐ Other (Specify) Frederick, Maryland 21. Signature of Pyneral Ser 22. Name and Address of Facility
Molesworth-Williams P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 20872 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final temon **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) -purial-Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physiclan/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s 24a. Was an autonsy certificate perforn 1 □Yes 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 28d. Describe how injury occurred 5 Pending investigation 1 Natural
2 Accident death. 1 ☐ Yes 2 ☐ No 24 hours after deat Funeral Director: filled in by the 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) To the I within 2 29c. License number 29d. Date sig MOS8726 L () 29b. Signature and title of certifier

State

31. Date filed (Month

Name and address of person who completed cause of death

2008

32. Registrar's Signature

Registrar

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of	Maryland		artment o <i>rtificate</i>			ind Me	ental Hy	/gien Reg. N	001	18	43	300
1974			Decedent's Name (First, Middle,	Last)						2	2. Date of D	eath			3. Time o	of Death
8	Physici		James Keith Bol	9.6						D	Month ecemb		ay 28, 20	Year 108	8:32	$\Delta^{\text{inf}}$
Y	/Medic		4a. Facility Name (If not institution,		ber)		4b. City, To	wn, or Lo	ocation o				c. County c		10.52	- 21
			28005 Barnes Ro	ad			Monrov	via				F	reder	ick		
	Funeral		5. Social Security Number	5. Sex 7 1 <b>X</b> M 2 □ F	. Age (In yrs. las		If Under 1 Months D		If Under 2 Hours	Min. 8	B. Date of Bi (Month, D	ay, Yea	r)	Cour	place (State	
	Director		235-46-8151	TIMEN ZUF	77	Yrs.				I	Dec. 9		931 1	West	Virg	inia
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	cation							1	Od. Inside (	City Limits
	f sho	o	W 1 1 T- 1	. 1	26									į	1 ☐ Yes	2 <b>X</b> No
	the 28a-	Director	Maryland Freder  10e. Street and Number	ıck	Monro	ovia	10f. Zip Co	ode				10g. C	itizen of W	hat Cour	ntry?	
	3a or		28005 Barnes Ro	ad			21770	)				USA				
	ms 2	Funeral	11. Marital Status	12. Was Deced	ent Ever in U.S.	. 13. 1	Nas Deceden	nt of Hisp	oanic Orig	gin? (Speci	ify Yes or N		14. Race		can Indian,	
9	or ite	Ē	1 ☐ Never Married 2 X Marrie	Armed Ford 1 [X] Yes 2 If Yes, Give	No Kore	an	if Yes, specify 1 □ Yes 2 ☑		, mexican Specify:	, Puerto Ri	ican, etc.)			, White,	etc.	
5-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. I Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	d by	3 Widowed 4 Divorced	Year or Dat	es: War		ILL Tes 2L2	7140	эреспу.				Specify:	Whi	te	
5-0	72 h 'natu dical	Completed	15. Decedent's (Specify only highest	Education grade completed)		16a. Dece	dent's Usual C kind of work of DO NOT use i	Occupati done dui	ion ring most	of working	7	î.	Kind of Bus			
2121	within ene. than " he Mec	ם	Elementary/Secondary (0-12)	College (1-								C 8		-	none C	omp./
2	filed withi Hygiene. other than ent, the M		17. Father's Name (First, Middle, L	l I	(	Chief	Purcha				First, Middle	Maide		izor	1	
Maryland	d 2 should be fi th and Mental H ?7 is marked otl traumatic ever	Be c		431)						,			n oumame	•/		
Z	hould mark	٤	Charles Boles  19a. Informant's Name/Relationshi	n (Type Print)		19h Mailir	ng Address (S				Nich		or Town S	State 7ir	Code)	
Ma	id 2 s Ith ar 27 is trau				rrifo											
	of Health item 27		Sarah Irene Bak 20a. Method of Disposition	er bores,	20b. Pla	ce of Dispo	Barne (Name	of	1	Da			Location - 0		L770 own, State	
no	0 0		1 X Burial 2 □ Cremation 4 □ Donation 5 □ Other (Sp		tate	-	matory or othe		i i	12/	21/200	0 D			Mass. 1.	
Baltimore,	# £ # =		21. S nature of F neral Service L	_	Betn	esaa 22	Method 2. Name and A	Address	of Facilit	12/. VMo.1o	31/200	h-Ui	amasc	us,	maryı	Homo
Ba	permi Depa Impo any Ir		Nau M	Don	-C-		6401 Ri								20872	
	- N		23a. Par 1. Enter the disease, or of shock, or he int failure. List of	omplications that ca	sed the death.								aryra		Approxima	ite
	Physician		Immediate - ouse (Final											4	Interval Be Onset and	Death
1	/Medical		disease or condition resulting in death)		<b>i-Infarc</b> ras a conseque		ientia							<u>P</u>	<u>fonths</u>	
18	Examiner		0	Recui	rent CV	/A's								N	lonths	
	D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter or or injury		r as a conseque											
	ecute ind trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	·	oral Vas		Disea	ise						1	<i>l</i> onths	-Year
8760,	cate be executed ohysician and the burial-transit		rooding in dodiny East	Due to (o	r as a conseque	ence ot):										
87	The law requires that the death certificate be executed the hea been signed by the attending physician and tage 2 should be detached for use as the bunal-transit	Physician/Medical	,	d										-		
9 x	leath certific attending pl	/Me	IF FEMALE:	23c. If yes, outcome	ome of pregnance	cv							004 D-4-			
Box	atten for u	cian	23b. Was decedent pregnant in the past 12 months?	1 ☐Live bir	th 2 Fetal d	leath 3[	Ectopic preg					- 1	23d. Date Mon		Day	Year
0	at the de by the stached	ıysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknov			( - / - /									
<u> </u>	res that igned b be deta		Part II. Other significant condition	ns contributing to dea	th but not result	ing in the u	nderlying caus	se given	in Part I.		23e. Did	tobacco	use contri	bute to t	he cause of	death?
rds	quire; n sign	d by									1 🗆	Yes	2□ No	3 <b>X</b> Prot	oably 4 □	Unknown
000	aw require s been się 2 should b	Completed									24a. Wa		24b. W	/ere auto	psy findings	available
Ä	The lay	E									auto per 1 Yes	opsy formed? 2 🔀 N	de de	nor to co eath? □Yes	mpletion of 2 ☐ No	cause of
ita		Be C	25. Was case referred to medical examiner?					2	26. Place	of Death (	(Check only					
or Vital Records,	dilis	일	1 Yes 2X No	Hospital: 1 ☐ In	patient 2 El	R/Outpatier	ıt 3∏ DOA	Other:	4□ Nu	rsing Hom	e 5 🔀 Res	sidence	6 □Othe	r (Specii	(y)	
			27. Manner of Death  1 X Natural 5 □ Pending	28a. Date of (Month	Injury 2 , Day Year)	28b. Time o Injury	f 28c	. Injury a Work?	at	28	3d. Describe	how inj	ury occurre	ed		
Sio	ent or:	atic	2 Accident investigation in Suicide 6 Could no	ation	_		M		es 2∐t	No						
Division	i or Atten after deatl Director: d in by the	Certification:	4 Homicide determin	20e. Place	of injury - At hom g, etc. <i>(Specify)</i>		eet, factory, c	office		28	Bf. Location City or To			r or Run	al Route Nu	mber,
	Hospital 4 hours a Funeral I tely filled		29a. Certifier 1 🔀 Certifying	Physician: To the t	act of my knowl	lodgo doat	h occurred at	the time	date an	d place, ar	nd due to th	0.001100	(c) and mar	apor oo a	teted	
	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical		xaminer: On the ba	sis of examination											(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	1111.		69	29c. L	icense r	number			29d. D	ate signed	(Month,	Day, Year)	
			>/Cell	UL_		AD	D264	400				Deco	mber	30	2008	
(	10)		30. Name and address of person w	ho completed cause	of death (Item 2	23a) (Type,		777				Jece	mne I	و 🗸 ر	2000	
			Ronald E. Miller	, MD, 4 C	ulwell	Drive	, Moun	t Ai	ry,	<u>Mary</u> l	Land	217	71			
44	Sta		31. Date filed (Month, Day, Year)	32. Re	oistrar's Signatu	ıre							- "			
	Registi	rar	BEC 3	0 2008	Achiel 1	15. 1	1									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2008 1 - For State Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** December 18, 2008 4:30 p M Thomas Lester Beetle /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel 1112 Spy Glass Drive Arnold If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Aug. 15, 1952 Birthplace (State or Foreign Country) 5. Social Security Number 6. S*e*x 7. Age (In yrs. last birthday) **Funeral** Hours Months Days 1**X** M 2□ F 56 New Jersey Director 041-46-3331 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 28a-f show of 2 should be filed within 72 hours after death with the Maryla th and Mantal Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, he "adden Express" unit or multing 1 ☐ Yes 2 → No Director Anne Arundel Arnold MD 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number 21012 USA 1112 Spy Glass Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1974 Black White etc. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1980 1 ☐Yes 2 No Specify: White Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Commerce Financial College (1-4or 5+) Elementary/Secondary (0-12) Vice President of Bank 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental Lester Beetle Patricia Conlan ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health at Important: If item 27 is any injury or other trau once. Diane G. Beetle/Wife 1112 Spy Glass Drive Arnold, MD 21012 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Dec. 30, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Atlantic Crematory Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 2008 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home Severna Park, MD 21146 495 Gov. Ritchie Hwy. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ACUITE MYO CARDIAL INFARCTION Physician /Medical Due to (or as a consequence of): Examiner ORONARY Anterosclerosi Se wentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed HYPERUPIDEMIA attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760, YRS Physician/Medical 14 SETES IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) signed by the a Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š SMUKING 1 Tes 2 No 3 Probably 4 Unknown cate has been signal page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 ☐Yes 2 ☐No 25. Was case referred to medical examiner? 26. Place of Death (Check onli one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1. Natural 1 ☐Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Lertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 29d. Date signed (Month. Dav. Year) 29b. Signature al of certifie 037664

Registrar
DHMH 17 Rev 1/2001

277 PENINGHLA

FARA RD

ARNOLD

21012

MI

30. Name and addr ss of person who completed cause of death (Item 23a) (Type, Print)

MO

32. Registrar's Signature

CHAMBERLAIN

31. Date filed (Month, Day, Year) DEC 2 4 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene?

			For State Registrar	State of Maryland	Cer	rtificate of L	Death	Re	g. No.	18	43302	
	Physicia		1. Decedent's Name (First, Middle, Las James S. Brennan	at)				2. Date of Death Month December	Day '	Year 08	3. Time of Death 5:55 p M	
all are	/Medic Examin		4a. Facility Name (If not institution, give	e street and number)		- J	Location of Death		4c. County o	f Death		
will <sup>i</sup>			834 Cottonwood Dr		at hirthday	Seve:	rna Park	9 Date of Birth			undel	
Ь	Funeral Director		213-30-3232	ex 7. Age ( <i>In yrs. la</i> <b>75</b>	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Sept. 23	Year) 3,1933	Mar	lace (State or Foreign try) cyland	
	Maryland a-f show	ctor	Usual Residence of Decedent  10a. State 10b. County Anne Anne Anne Anne Anne Anne Anne Ann		Town or Loverna					16	0d. Inside City Limits 1 ☐ Yes 2 🎇 No	
	h with the 23a or 28 at be no	Funeral Director	10e. Street and Number 834 Cottonwood Di	rive		10f. Zip Code 21146		10	g. Citizen of WI	nat Coun	try?	
980	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Exprinter must be notified at		11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 Myes 2 □ Nore If Yes, Give Year or Dates: War	an   13. \	Was Decedent of H fYes, specify Cuba I∐Yes 2 X No	ispanic Origin? (Sp un, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race Black Specify:	White, e		
1215-0	vithin 72 ho ine. han "natu u Modicel	Completed by	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	de completed)  College (1-4or 5+)	(Give life. L	dent's Usual Occup kind of work done of DO NOT use retired pervisor	ation during most of work f)	ing	6b. Kind of Bus		•	
Baltimore, Maryland 21215-0036	ld be filed v lental Hygie <b>ked other i</b> ic event, <u>u</u>	To Be Co	17. Father's Name (First, Middle, Last)  John Nicholas Bro					ame (First, Middle, Maiden Surname) auline Tokarz				
, Mary	1 and 2 shou Health and M em 27 Is mar other traumat	_	19a. Informant's Name/Relationship ( Amy S. Brennan/ W.	**			and Number or Rui					
imore,	permit. Pages 1 and Department of Heal Important: If Item 2 any Injury or other once.		20a. Method of Disposition  1 Burial 2 ACremation 3 4 Donation 5 Other (Specify	oc. Location - C Glen Bur	•							
Balt	permit. Depart Import any Inj once.		21. Signature of Funeral Service Licen	See ACC	B 4	arranco 8 95 Gov. F	Sons, P Ritchie H	.A. Seven	rna Park rna Park	Fur M	neral Home 21146	
	Physician /Medical Examiner		23a. Part 1 Enter the disease, or com, shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequent).	ence of):	er the mode of dyin		or respiratory arre	est,	Ž	Approximate Interval Between Onset and Death	
68760,	tificate be executed g physician and as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C								
Вох	Hospital or Attending Physician: The law requires that the death certific 4 hours after death. Funeral Director: After this certificate has been signed by the attending p strengly filled in by the funeral director, page 2 should be detached for use as	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnal 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of do 9 ☐ Unknown	death 3[	☐ Ectopic pregnanc ☐ Other (specify) _	у		23d. Date Mon		ery Day Year	
rds, P	quires that in signed b uld be deta	d by Pr	Part II. Other significant conditions of	contributing to death but not resu	Iting in the u	nderlying cause giv	en in Part I.				ne cause of death?	
Division of Vital Records, P.O.	The law re- cate has been page 2 short	Complete	DIABETES  REWAL FAIL	MRE, HYP	ea the	ISDON		24a. Was ar autopsy perform 1 🗆 Yes 2	ned? pr	ere auto ior to cor ath? ☐Yes	psy findings available mpletion of cause of	
Vita	certifi rector,	Be	25. Was case referred to medical examiner?	Hospital:		oth Oth	er.	th (Check only one				
on of	ding Physician: The In. After this certificate hit funeral director, page	tion: To	1  Yes 2  No  27. Manper of Death 1  Natural 5  Pending 2  Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time o Injury	f 28c. Injur	y at	ome 5 PReside 28d. Describe ho			y)	
Divisi	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		me, farm, str			28f. Location (Sti City or Town	reet and Numbe , State)	r or Rura	il Route Number,	
	ne Hospital 24 hours a ne Funeral I	Medical C		nysician: To the best of my knowniner: On the basis of examination and manner stated.								
	To the within 2 To the comple	Me	29b. Signature and title of certifier	ó /		29c. Licens			d. Date signed			
	Lika.	3	30. Name and address of person who	suchles in		D 2.	1114	Ü	ECEM BE	il d	2,2000	
	1.00		30. Name and address of person who	completed cause of death (Item	23a) (Type,	Print) DAMA	AN E	BERCHE	S MD	9		
	Sta	ite	5 Y(1 OC 1) FREDE (1) 31. Date filed (Month Day, Year) DEC 2 4 20	10 37 Registrar's Signar	re	SH-IN	WELL IN	MATERIA	2/1/			
	Regist		UEU 2 4 20	UO Carona B	. Lya	Comment						

State of Maryland /	Department of Health and	Mental Hygien
	On all time to a f Donath	

	•	For State Registrar	State of Ma	•	Certificate of I		Reg	No. 200	8 43303
Physicia	an	1. Decedent's Name (First, Middle, L					2. Date of Death Month DECEMBER	Day 200	3. Time of Death <b>11:35 A</b> M
/Medic		WILLIAM ERNEST B			4h City Town o	Location of Death	DECEMBER	4c. County of De	
Examin	er	4a. Facility Name (If not institution, gi			FORT WAS	_		PRINCE G	
Funeral				e (In yrs. last birt	hday) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. B	irthplace (State or Foreign
Director		271-48-2926	1 M 2 □ F	60	Yrs. Months Days	Hours Min.	AUGUST I,	1948 OF	IIO
w.		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
Maryli f sho led at	0	MARYLAND PRINCE	GEORGES	FORT W	ASHINGTON				1 TayYes 2 □ No
r 28a- notif	rec	10e. Street and Number	02011025		10f. Zip Code		10g	. Citizen of What	Country?
h with	Funeral Director	1493 POTOMAC HEI	GHTS DRIVE		2074	44	U	NITED ST	ATES
ems ems	ıner	11. Marital Status	12. Was Decedent I Armed Forces?	Ever in U.S.	13. Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - An Black, Wh	nerican Indian, nite, etc.
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Fu	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	1. Yes 2 □ N If Yes, Give Year or Dates:	10	1 □ Yes 2 <b>X</b> No				BLACK
2 hou	ted I	15. Decedent's l	Education	16a.	Decedent's Usual Occup	ation	ring 16	b. Kind of Busines	s/Industry
thin 7 le. lan "n Medi	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+}	(Give kind of work done life. DO NOT use retired			EDEDAT C	OMEDMENT
lygien lygien ner th it, the		12TH GRADE			FINGER PRIN				OVERNMENT
be fill	Be	17. Father's Name (First, Middle, Las JAMES HENDERSON					e (First, Middle, Ma THOMPSON		
hould d Mer marke	٦	19a. Informant's Name/Relationship		19h	Mailing Address (Street				Zin Code) 207///
nd 2 salth an 27 is r		MARY JUDINE BOLD		I	93 POTOMAC 1				
es 1 ar of Hea fitem r othe		20a. Method of Disposition	Demoval from State	20b. Place of cemeter	Disposition (Name of y, crematory or other place	ce)	Date 20	c. Location - City	or Town, State
Pagement ant: If uny o		1  Burial 2  □ Cremation 3 4  □ Donation 5  □ Other (Spec		MARYLAN	D VEIERANS CEMI	TIERY JAN.	5, 2009 O	HEITENHAM,	MARYLAND
permit. Depart Import any inj		21. Signature of Funeral/Service Lie	ensee to John	750	THORNTON F	UNERAL HO	ME, P.A.		
GD = 60		LYDIA C. THORNTON  23a. Part1. Enter the disease, or co							ARYLAND 20640 Approximate
		shock, or heart failure. List onl	y one cause on each lir	ie.		ig, sucit as caldiac	or respiratory arres	la .	Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	a. My eco	a consequence of	Zorfanti IN				
Examiner	Examiner		Hya	Lanc 2	1				Urs
B-10-		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of	of):				1'
cuted nd ransit		that illuated events	c						
rtificate be executed ig physician and as the burial-transit		resulting in death) Last	Due to (or as	a consequence o	of):				
cate b	ledical								
		IF FEMALE:	23c. If yes, outcome	of pregnancy				23d. Date of	deliven
atten for u	cian	23b. Was decedent pregnant in the past 12 months?		2 Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	/		Month	Day Year
the d by the	Physician/N	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknown						
w requires that the death cer been signed by the attendir should be detached for use	by Pł	Part II. Other significant conditions	contributing to death be	ut not resulting in	the undertying cause giv	en in Part I.	23e. Did toba	cco use contribute	to the cause of death?
equire en sig ould b							1 Yes	2 No 3	Probably 4 ☐Unknown
law re as be 2 sho	Completed						24a. Was an autopsy	24b. Were	autopsy findings available o completion of cause of
siclan: The law s certificate has t irector, page 2 s	Com						performe		?
clan: ertific	Be (	25. Was case referred to medical examiner?	Linearitali		l ou		th (Check only one)		
Physi this c	ဥ	1 ✓ Yes 2 No  27. Manner of Death	Hospital: 1 ☐ Inpatie		·	4 □ Nursing He	ome 5 Residen		pecify)
ding I h. After funer	lion	1 Natural 5 ☐ Pending	(Month, Da		njury Wor	k? K? Yes 2∐No	28d. Describe how	injury occurred	
Atten deatl	fica	3 Suicide 6 Could not	be 28e. Place of inju	ury - At home, fa	rm, street, factory, office				Rural Route Number,
s after	Certification:	4 ☐ Homicide determine	building, et	c. (Specify)			City or Town,	State)	
To the Hospital or Attending Physician: The law requires that the death ce within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attendit completely filled in by the funeral director, page 2 should be detached for use	Medical (			f examination an	e, death occurred at the ti d/or investigation, in my				
fo the vithin fo the	Mec	29b. Signature and title of certifier	2/		29c. Licens	e number	290	I. Date signed (Mo	onth, Day, Year)
C > F 0		· YM	m.		D005°	1658	13	129/08	
		30. Name and address of person wh	o completed cause of d	eath (Item 23a) (	(Type, Print)	4 : 4 =		1640	
R 4+1		31. Date filed (Month, Day, Year)	2 104 Old BIG	ar's Signature	we Trough	H1115, Mar	yland 207	48	
Sta Registr		DEC 3	0 2008	eres the	forte				
		DECO	- 2000	50					

State of Maryland / Department of Health and Mental Hygiene rgiene Reg. No. 2008 43304 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Edward E. Bitner /Medical Dec. 2008 8:29 AM 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll County Medical Center Westminster Carrol1 5. Social Security Number If Under 1 Year | If Under 24 Hrs. **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Aug. 18 Birthplace (State or Foreign Country) 1√2 M 2 □ F Months Days Hours Min. Year Director 199-07-5822 89 PA Usual Residence of Decedent 10a State show 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Examinat must be notified at MD Carroll Westminster Director Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 507 High Acre Apt. 101 21157 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, within 72 hours after Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1945–46 à 1 Yes 2 No Specify: 3 ₩ Widowed 4 □ Divorced Specify white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) engineer plane mfg. 17. Father's Name (First, Middle, Last) if 2 should be firth and Mental F 7 is marked ott Be 18. Mother's Name (First, Middle, Maiden Surname) Emory T. Bitner Mabel Ensign 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 a Department of Health ar Important: If item 27 is any injury or other trau Emily B. Jorss 510 T4 Pinehurst Circle, Westminster MD 21158 20a. Method of Disposition

↑ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Green Hill Cemetery 01/05/2009 Waynesboro, PA 4 Donation 5 Dother (Specify) 22. Name and Address of Facility
Grove-Bowersox Funeral Home, Inc.
50 South Broad Street, Waynesboro PA 17268 21. Signature of Funeral Service. Licensee ames R. Barrersa 23a. Part | Enter the disease, or complications that of used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, short, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death **Physician** disease or condition /Medical resulting in death) Due to (or as a consequence of): Examiner perlupe Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE: for use 23b. Was decedent pregnant in the past 12 months? If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month 5 Other (specify) Day Year ned by the □Yes 2 No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☑ No 3 Probably 4 ☐ Unknown been action our has 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed' replacement 001 tro 1 ☐ Yes 2 ☐ Mo 2 No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? s after death.
al Director: After this כי Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🔲 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide e Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 6/3/18 00056763 30. Name and address of person who completed cappe of death (Item 23a) (Type, Print) 5H20H WESTMIN ERNESTO WASHINGTON RD, STELZO MENDOZ 826 31. Date filed (Month, Day, Year) State 32. Registrar's Signature Registrar JAN 05

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Physic /Med Exami

**Funeral** Directo

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 273a or 28a-f show any Injury or other traumatic event, the Modical Examination or other traumatic event, the Modical Examination or other traumatic event, the Modical Examinations.

Baltimore, Maryland 21215-0036

**Physician** /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

	1 - State Registrar	C	Certificate of Death	<u>.2008 43305</u>									
ian	1. Decedent's Name (First, Middle, Last)			2. Date of Death Month D	3. Time of Death								
cal	Clarence W Bosker		Tu a	12	17 208 1930 M								
ner	4a. Facility Name (If not institution, give street and number)  And And O Mudeel (	a de a	4b. City, Town, or Location of Dea		c. County of Death								
	5. Social Security Number 6. Sex 7. Age	(In yrs. last birthd	ay) If Under 1 Year If Under 24 Hr		9. Birthplace (State or Foreign								
	220-36-5568 <sup>1</sup> ♥ <sup>M 2□</sup> F	69 Yrs	Months Days Hours Mir	June $10^{Month, Day, Yea}$	939 Maryland								
	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or	Location		10d. Inside City Limits								
٥	Maryland Anne Arundel	•			1√2 Yes 2 □ No								
rect	10e. Street and Number	Annar	10f. Zip Code	10a. C	Citizen of What Country?								
io O	18 Hicks Ave		21401		USA								
ner	11. Marital Status 12. Was Decedent E- Armed Forces?	ver in U.S. 1	Was Decedent of Hispanic Origin? (     If Yes, specify Cuban, Mexican, Pue	Specify Yes or No-	14. Race - American Indian,								
Y Fu	1 Never Married 2 Married 1 Yes 2 No	0	1 ☐Yes 2 <b>X</b> No Specify:	rto nicari, etc.)	Black, White, etc.  Specify: Black								
Completed by Funeral Director	3 Widowed 4 Divorced Year or Dates:	160 Do		101									
plet	15. Decedent's Education (Specify only highest grade completed)	(G	ecedent's Usual Occupation iive kind of work done during most of w e. DO NOT use retired)	releina	Kind of Business/Industry ate Highway								
mo:	Elementary/Secondary (0-12) College (1-4or 5+	)	Laborer		ministrator								
BeC	17. Father's Name (First, Middle, Last)			me (First, Middle, Maide									
5	Moses Boston		Sarah	Olney									
	19a. Informant's Name/Relationship (Type. Print)		ailing Address (Street and Number or F	Rural Route Number, City	or Town, State, Zip Code)								
١.	Louis J. Boston(Brother			Clinton, M									
	20a. Method of Disposition 1	cemetery,	rpstiem (Name of crematory or other place) al Park 12-		Location - City or Town, State								
12	4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee	riemor i	Miniame Revenues of Secili Sor		napolis, Md.								
	Lann 1. Beese MOOY83		821 West St. Ar	napolis,	y, F.A. Md. 21401								
	23a. Part1. Enter the disease, or complications that caused t	he death. Do not			Approximate								
ß (	shock, or heart failure. List only one cause on each line	1 0.			Interval Between Onset and Death								
П	disease or condition resulting in death)  a	consequence of):	unince										
	2 Sophereal Carar												
ine	Sequentially list conditions, if any lead in the interpretation cause. Enter Underlying Cause (Disease or injury that initiated events c.												
хап		consequence of):											
E E		ooneequonee siy.											
Medical Examiner	u.	-,											
	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome o	f pregnancy	2 🗆 🗆	Į.	23d. Date of delivery								
sicia	in the past 12 months?  1		3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month Day Year								
Completed by Physician	9 Unknown												
b d	Part II. Other significant conditions contributing to death but	not resulting in the	e underlying cause given in Part I.		use contribute to the cause of death?								
eted	Taxae is 170.			1 ☐ Yes 2	2 No 31 Probably 4 Unknown								
dm				24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of								
	OF Was ages referred to modical			performed? 1 □Yes 2 □N	death? 1  Yes 2 No								
o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☑ npatien	t 2 🗆 EP/Outpo	Otheru	ath (Check only one)	• For								
n: T	27. Manner of Death 28a. Date of Injury	28b. Time	e of 28c. Injury at	Home 5 ☐ Residence									
atio	1 Natural 5 Pending (Month, Day, 2 Accident investigation	Year) Injur	y Work? M 1 ☐ Yes 2 ☐ No										
tific	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injur building, etc.	y - At home, farm, (Specify)	street, factory, office	28f. Location (Street a City or Town, State	and Number or Rural Route Number,								
Cer													
Medical Certification: To	29a. Certifier (Check only one) (Check only one) (Check only one)	examination and/o	eath occurred at the time, date and place r investigation, in my opinion, death occ	ce, and due to the cause( curred at the time, date ar	s) and manner as stated.  nd place, and due to the cause(s)								
Med	29b. Signature and title of certifier	eu.	29c. License number	29d. D.	ate signed (Month, Day, Year)								
	Para Il Carrella de	•	D66570										
	30. Name and address of person who completed cause of dea	ath (Item 23a) (Tyr	De Brint)		10(1110)								
	Amy Crude MD 2	(W) ( Me	Jake Perlina	y Horapol	12/17/08 Pes NO 2/401								
ite	31. Date filed (Month, Day, Year) 32. Registrar	's Signature	1.41	)									
rar	UEG I D 2000 Kleve	u p.	Garri										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #8 Pestale of Man land 92/09 art ent of Health and Mental Hygiene 43306 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** 22,2008 Ruth Craig December 9A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Arbor at Baywoods Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth 10/02/19 Bethplace (State or Foreign (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2**)** F Director 208-01-5086 94 <u>Pittsburgh PA.</u> Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. am 27 is markad other than "netural", or Items 23a or 28e-f show 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 7 is markad other than "netural", or Items 23a or 28e-f show traumatic event, the Medical Examinations as the rediffed at Anne Arundel Annapolis 1 ☐ Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7101 Bay Front Road 21403 USA Funerai 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2/☐XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐(No Specify: Specify: White δ 3 □XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Secretary Life Insurance 12 02 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Walter Reber Margaret Howells 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) If itam 27 POA Nephew 128 Kirwan Landing Lane Chester, MD 21619 Richard Brown 20b. Place of Disposition (Name of cometery, crematory or other place)
Atlantic Crematory Date 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 ☐ Burial 2 XCremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. 12/23/08 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 21401 21. Signature of Suneyal Service Licenses 22. Name and Address of Facility Hardesty Funeral Home P.A. 12 Ridgely Ave ANN, MD als 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 20 minutes disease or condition resulting in death) /Medical Due to (or as a consequence **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy ŏ in the past 12 months?
1 ☐ Yes 2 No
9 ☐ Unknown Month Day Year 4☐ Pregnant at time of death 5 Other (specify) detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Dementia Advanced 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 Tes To the Hospital or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) P 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To tha Funaral Diractor: A investigation completely filled in by the 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 0029571 who completed cause of death (Item 23a) (Type, Print) Defense Hwy, Crofton, MDZIII4 31. Date filed (Month 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001

			1 - State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2008	43307
	Dhusisi		1. Decedent's Name (First, Middle, Last)  2. Date of Death	3. Time of Death
	Physici /Medic		Alan Samuel Corcon December 2/ 2009	12:25 A <sup>M</sup>
	Examin	er	A 17 (2) 114	
and "	Comment		Alfredhouse Eldercare Rockville Montgomer  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year   If Under 24 Hrs.   8. Date of Birth 9. Birth	hplace (State or Foreign
	Funeral Director		Months Days Hours Min. (Month, Day, Year) Col	sylvania
	pu »		Usual Residence of Decedent	
	laryla shov	ō	10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	28a-	Director	MD Montgomery Silver Spring  10e. Street and Number 10f. Zip Code 10g. Citizen of What Cot	
	be filed within 72 hours after death with the Marylan tital Hygiene. d other than "natural", or items 23a or 28a-f show event, If a Medical Examiner must be notified at	al Di	To   15320 Pine Orchard Drive #1K   20906   USA	may.
	death	Funeral	11. Marital Status  12. Was Decedent U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces?  14. Race - Amerital Status  15. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces?)  16. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces?)	
36	or ite		If Yes Give 1 Yes 2 No. Specify:	, etc.
<u> </u>	hours tural"	ed by	1 3 widowed 4 Divorced   Year or Dates: 14/13_/15	ite
21215-0036	in 72 n "na nedic	Completed	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  16b. Kind of Business/I	ndustry
212	d with giene er tha	Com	Elementary/Secondary (0-12) College (1-4or 5+)  5+ Engineer Federal Gov	ernment
g	be file tal Hy d oth event	Be (	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)	
<u>\S</u>	should be filed within 72 hours after death with the Maryland ind Mental Hygiene. I marked other than "natural", or items 23a or 28a-f show unatic event, if a Marical Examiner must be notified at	_C		
Maryland			19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Z  15320 Pine Orchard Drive #IK Silver Sprint	
ā,	les 1 and 2 should be filed to f Health and Mental Hygi If Item 27 Is marked other or other traumatic event, II		20a. Method of Disposition 2 Date 20c. Location - City or 7 Cermetery, crematory or other place)	<u> </u>
altımore,	Pages nent of unt: If Its ury or o		1 □ Burial 2 ☑ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)  W. Arundel Crematory 12/26/08 Odenton, MD	- · · · · · · · · · · · · · · · · · · ·
<u>=</u>	permit. Pages Department of Important: If II any injury or once.		21 Signature of Funeral Service Licensed 2 22 Name and Address of Facility	- 70/
n	90 <b>= 60</b>		Going Home Cremation Service P.O. Bo Beverly L. Heckrotte, P.A. Clarksvill	e, MD 21029
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	Approximate Interval Between Onset and Death
and .	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. Alzheimer's Disease	
	Examiner		Due to (or as a consequence of):	
	B =	ner	Sequentially list conditions, if any, leading to immediate course great Underlying  Due to (or as a consequence of):	
	ecuter ind transi	Examiner	Cause (Disease or injury that initiated events c.	
60,	ficate be executed physician and s the burial-transit	Ē	resulting in death) Last  Due to (or as a consequence of):	
98760	ficate physics the I	edical	Ö d	
XOX	n certif	J/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 23d. Date of deliv	venu
Ď.	e law requires that the death certifi has been signed by the attending ie 2 should be detached for use as	Physician/M	in the past 12 months?  1	Day Year
7. O	at the d by the stache	hys	9 Unknown 9 Unknown	
Š,	res th signed be de	à	23e. Did tobacco use contribute to	
Š	been sign	eted	1 Yes 2 WNo 3 Pro	bbably 4 ☐ Unknown
Hecords,	he law has b	Completed	24a. Was an 24b. Were aut prior to compare the company of the comp	opsy findings available ompletion of cause of
N [a]	an: TI tifficate or, pa	ပ္ပ	43 OF Was asso referred to madical	2 🗆 No
=	ysicia is cer direct	To B	examiner?	assisted
n 01	ng Ph fter th neral	ı.	The state of the s	MY TIATUR
<u> </u>	tendir eath. or: A the fu	catic	Table to the state of the state	
DIVISION	or At after d Direct in by	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Run City or Town, State)	al Route Number,
_	spital ours a neral I			
	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page.	edical	(Check only one)	stated. to the cause(s)
	To th Within To th comp	Me	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month)	, Day, Year)
	7+1		Davillare Chylery, M D59373 December 24	, 2008
	EGI		30. Name and address of person who completed cause of death (flem 23a) (Type, Print)  Dawn Marie Christerson, M.D. 3720 Farragut Ave. 2nd Floor Kensington, MD	
	Sta	e.	31. Date filed (Month, Day, Year) 32. Benistrate Signature	
	Registra			

			For State Registrar		State o	f Marylan		artment rtificate			ind M	ental F	lygier Reg. 1	200	3	43308	3
21 4	Physici		1. Decedent's Name (First, John D									2. Date of Month Dece		18 20	ear 008	3. Time of Death 9:18 p.	
44	/Medic Examin		4a. Facility Name (If not inst			mber)		4b. City, To	own, or L	ocation o	f Death			4c. County of	Death		
		Ž	Chesapeake				to a friends at a 1	If Under 1		idge	DA Hrs	O Data of	Right	Doro			- /
墓.	Funeral Director		5. Social Security Number 220–12–1462	6. Se	X DM 2□F	7. Age (In yrs. 83	Yrs.		Days	Hours	Min.	8. Date of (Month, Jan.	Day, Ye.			place (State or Fore ntry) 1land	3ign
-	Du *		Usuaf Residence of Decede  10a. State 10b. Co			10c. Cit	y. Town or Lo	ocation							1	0d. fnside City Lim	nits
	r 28e-f ehow	tor		orche	ester		,,		mbri	.dge						1 <b>X</b> Yes 2□	
+-	or 28s	Director	10e. Street and Number	-				10f. Zip 0		542			10g.	Citizen of Wh	at Cour	itry?	
3	r death w	Funeral	414 Phillip	s ave		edent Ever in U	S. 13.	Was Decede		613	nin? (Spe	city Yes or	No-	USA 14. Race	Americ	an Indian,	
)36	72 hours after death with the Maryland naturel; or iteme 23e or 28e-f ehow dical Exami ar must be notified at	Ď	1 □ Never Married 2 □ 3 ☑ Widowed 4 □ Div		Armed Fo	orces? 2 □ No		If Yes, specif	y Cuban	Specify:	, Puerto F	Rican, etc.		Specify:	white, wh	etc. nite	
5-0	72 ho 'natur	eted	15. Dec (Specify only	edent's Edu			16a. Dece (Give	dent's Usual kind of work DO NOT use	Occupat	ion iring most	of working	ng	16b	. Kind of Busi	ness/in	dustry	
Maryland 21215-0036	be filed within ital Hygiene. Id other then "I event, the Mer	Completed	Elementary/Secondary (0	-12)	College (	1-4or 5+)		welder					,	wire c	loth	ı mfg.	
pu	s 1 and 2 should be filed within f Health and Mental Hygiene. Item 27 is marked other then other treumatic event, the Ma	Be	17. Father's Name (First, M.											den Sumame)			
ryla	hould d Men marke	은	John Herman				19b. Maifi	na Address (	Street ar			lizab <i>Boute Nu</i>	77.11	COX ty or Town, Si	ate. Zio	Code)	
Ma	nd 2 s aith an 27 is i		Judy C. Crei			ghter										23454	
ore,	ges 1 a it of Hea if item or othe		20a. Method of Disposition 1   Burial 2 □ Crema	ıtion 3 □	Removal from		Place of Dispo cemetery, crea	sition (Name	of		D	ate		. Location - C			
Baltimore,	permit. Pages 1 and 3 Department of Health Important: If item 27 eny injury or other tru once.		4 Donation 5 Ott	ner (Specify,	)		yland Y	Vetera  Name and		-	_	29/08		urlock eral Ho			-
Ва	Department of the property of		▶ HLLT	lom				700 Lo			. 11					P.A.	
L.C.	Physician		23a. Part1. Shter the diseas shock, or heart failure immediate Cause (Final disease or condition resulting in dealh)	se, or comp List only o	a. La	each line.	>/ C			, such as	cardiac o	r respirato	y arrest,			Approximate Interval Between Onset and Death	
	/Medical Examiner		Todaking in doubly			or as a conseq	quence of):										
	<b>₽</b> ∺	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		b. Due to	(or as a conseq	quence of):										
	axecute	Examiner	that initiated events resulting in death) Last		c. Due to	(or as a conseq	juence of):								-		-
8760,	cate be executed bhysicien and the burial-transit	dicai		l	d												
99 X	aath certifica attending pl for use as t	/Med	IF FEMALE:		23c. If yes, ou	tcome of pregna	ancv		-					23d. Date	of delive	any	
P.O. Box	that the death ed by the atter detached for u	hysician	23b. Was decedent pregna in the past 12 months 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	nt j	1 ☐ Live I	birth 2 Fete	eldeath 3	Ectopic pred Other (spe						Monti		Day Year	
rds, P	Attending Physician: The law requires that the death certificate be executed refath. refath. ector: After this certificate has been signed by the attending physicien and by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/Me	Part II. Other significant co	nditions co		leath but not res			use givei	n in Part I.			/			he cause of death? bably 4 ∐Unkno	
Vital Records,	The law rate has be page 2 sh	Comple	stroke,								-	a	Vas an utopsy erformed s 2 2	pri de	or to co ath?	ppsy findings availa mpletion of cause 2 No	abfe of
Vita	ysician: The is certificate hi director, page	Be	25. Was case referred to mexaminer?	-	Hospital:				Othe			(Check of			12 Vin 16		
of	ding Phys h. After this funeral di	n: To	1 Yes 2 No 27. Manner of Death		1 🗆	Inpatient 2 of Injury oth, Day Year)	28b. Time o		c. fnjury Work	4 💆 Nu				6 Other		<i>y)</i>	
Division of	tending t eath. tor: After the funer	catio	2 Accident	ending nvestigation Could not be				М	1 🗆 Y	es 2 🗆 I							
Divi	al or At after d 1 Direct d in by	Certification:		etermined	286. Plac	e of Injury - At h ling, etc. <i>(Specil</i>	ome, farm, st fy)	reet, factory,	office		2		n (Stree Town, S		or Rura	al Route Number,	
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi	Medical C	29a. Certifier 1 Ce (Check only one) 2 Me	rtifying Phy dical Exam	niner: On the b	e best of my kno basis of examina nner stated.	owledge, deat ation and/or in	h occurred a vestigation, i	t the time n my opi	e, date an inion, dea	d place, a	and due to ed at the ti	the caus ne, date	e(s) and mani and place, an	ner as s d due to	tated. the cause(s)	
	To the within 2 To the complet	M	29b. Signature and title of o	ertifier	~	لها		29c.	License	number	300	"	29d.	Date signed	Month.	Day, Year)	
			30. Name and/address of p	XOI		so of death //-	m 22a\ /T:-=	Prin!)	110	05	17/	フ	/	0/17	10	5	
_			Patricia	Joh	4150x	se of death (Iter	Bra	PrinI)		Can	n br	ida	e N	10			
	Sta Registi		31. Date filed (Month, Day, DEC	2 2 2	2008 32	egistrar's Signa	ature	book	,			7					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month December 18, 2008 Physician 12:15 p<sup>M</sup> Rosemary D. Clanton /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Annapolis 724 Ballast Way Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🔀 F Yrs. Nov. 6, 1932 New Jersey 131-26-5722 76 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State ral", or items 23a or 28a-f show Examinar must be notified at 1 Yes 2 No **Funeral Director** Anne Arundel Annapolis MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with inent of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or items 23a or ury or other traumatic event, the Madical Examinas is until be not or other traumatic event, the Madical Examinas is until be not other traumatic event. USA 724 Ballast Way 21401 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White ģ 3 ₩ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Travel Agent Travel 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mildred Smith Harold Danforth ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If Item 27 is any Injury or other trau once. Arthur Clanton/Son 306 St. Ives Drive Severna Park, MD 21146 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition Dec. 20, 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Glen Burnie, MD 2008 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 22. Name and Address of Facility
Barranco & Sons, P.A.
495 Gov. Ritchie Hwy. 21. Signature of Funeral Service Licenses Severna Park Funeral Home Severna Park, MD 21146 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. a solicic Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. if yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by trice 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 🖟 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Amesidence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After this funeral 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural
2 Accident ours after death.
neral Director: Af 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 12-19-08 D57028 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Aditya Chopra M.
31. Date filed (Month, Day, Year)
DEC 2 3 2008 600 Ridgely Avenue #231 Annapolis maryland 21401 m.D. . Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 0 0 8 Certificate of Death 2. Date of Death 3. Time of Death 1 Decedent's Name (First, Middle, Last) Month Year **Physician** 10:32 A M Eileen S. Cleary 21, 2008 December /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Bowie Health Center Bowie | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year, July 21, 10) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 ☐ M 2 🖫 F 1920 Pennsylvania 88 Director 169-18-4171 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County Show r than "natural", or items 23a or 28a-f shov the Modical Examiner must be notified at 1 ☐ Yes 2 X No Crofton Completed by Funeral Director MD Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 2907 Middlebridge Court 21114 Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Items 23 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 No Specify: White Specify: 3 XWidowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Federal Government Secretary 18. Mother's Name (First, Middle, Maiden Sumame) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be Anna Gallagher Daniel Sheerin ို 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) f Health a Item 27 is other tra Colleen M. Cleary/Daughter 2907 Middlebridge Court Crofton, MD 21114 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State 20a. Method of Disposition Maryland Veterans 1 € Burial 2 Cremation 3 Removal from State = 5 permit. Page Department of Important: If any Injury or once. 12/24/2008 Crownsville, MD ^ 4 □ Donation 5 □ Other (Specify) Cemetery 22. Name and Address of Facility 21. Signature of Funeral Beall Funeral Home Bowie, MD 20715 6512 NW Crain Hwy. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician disease or condition resulting in death) Aspiration Pneumonia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine physician and s the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medicai as IF FEMALE use 23c. If ves. outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 0 4 Pregnant at time of death 5 Other (specify) Records, P.O. detached 9 Unknown 9 Unknown á 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Dementia 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No has 1 ☐ Yes Division of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient 2 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 2 this 28c. Injury at Work? in by the funeral 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 27. Manner of Death Certification: After (Month, Day Year) Injury 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No death. 2 Accident after death Director: 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours a 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical within 2 the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of e D45660 12-22-2008 30. Name and address of person who completed cause of death (Item 23a) Type, Print) Dpinder Singh, M.D. 14300 Gallant Fox Lane Bowie, MD 20715 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2008 Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar	State of Ma	ii yiai iu / i		ificate of L	Death		g. No. 200	8 43	3311		
	Physicia	an	1. Decedent's Name (First, Middle, Last Gladys Margi				2. Date of Death Month Decembe	er 26, 20	3. Time	e of Death				
	/Medic Examin		4a. Facility Name (If not institution, give		4b. City, Town, or	Location of Death	2000	4c. County of D		JO 1				
T and			Solomons Nursing Center Solo							Calvert				
	Funeral Director		233–38–9737		i (In yrs. last bii 3 <b>1</b> ———————		Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Aug. 2,	<sup>Year)</sup> 1927 Be	Birthplace (Sta Country) ckley,	WV		
	land ow		Usual Residence of Decedent  10a. State 10b. County		10d. Inside	e City Limits								
	e Mary a-f sh	ctor	MD St. Mary	's	Mech	anic	sville				1 □ Y	′es 2⊠No		
	n with the	al Director	10e. Street and Number 38981 Lupes Cour	·t			10f. Zip Code <b>206</b>	59	10	g. Citizen of What USA	Country?			
5-0036	be filed within 72 hours after death with the Maryland that Hygiene. do other than "natural", or items 23a or 28a-f show event, the Medical Exproducer must be redified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ♥ Widowed 4 □ Divorced  12. Was Decedent Ever in U Armed Forces?  1 □ Yes 2 ♥ No If Yes, Give Year or Dates:			U.S. 13. Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto 1 □ Yes 2 ☑ No Specify:					American Indian /hite, etc. White	1,		
5-0	72 ho "natur	eted	15. Decedent's Edu (Specify only highest grad	ucation de completed)	16a	(Give ki	nt's Usual Occup nd of work done o	during most of work	ing 1	6b. Kind of Busine	ess/Industry			
2121	be filed within 72 hortal Hygiene. d other than "natuevent, II'm Medical	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	+)		NOT use retired Comemaker			Own	Home			
שנ	e filed al Hygi other vent, I	Be C	17. Father's Name (First, Middle, Last)  William  Linkous  Gladys					e (First, Middle, M						
ylar	2 should be and Menta is marked aumatic ev	10	William		Gladys			hupe						
Maryland			19a. Informant's Name/Relationship (7) Gary Chick (son)					and Number or Rui ve Lane						
a)	es 1 and of Health f item 27 or other t		20a. Method of Disposition				tion (Name of tory or other place			Oc. Location - City		9		
Ē	Pages ment of ant: If its ury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State  ')		ar H	ill Ceme	tery 2	2008	Suitland	, MD			
Baltimore,	permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service Licens					ss of Facility Lec hern Mary				PA 20736		
war.	death certificate be executed  Wedical  e attending physician and for use as the burial-transit	cal Examiner	shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Resal Due to (or as a	a consequence	Of all	due to	Orabet 11.tus	c We h.	ispathy	Onset a	Between nd Death		
O. Box 68	he death certifica the attending ph thed for use as th	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown							23d. Date of delivery Month D				
ds, P.	law requires that the das been signed by the 2 should be detached	ρ	Part II. Other significant conditions co	ontributing to death bu	it not resulting i	in the uno	lerlying cause give	en in Part I.		acco use contribut	te to the cause			
Vital Records,	The lar ate has bage 2	e Completed	25. Was case referred to medical					36 Place of Dec	24a. Was an autopsy perform 1 □ Yes 2	/ prior ned? deat ☑No 1 ☐	e autopsy findir to completion h? Yes ANO	ngs available of cause of		
	Physiclan: r this certific ral director, I	0 8	evaminer?	Hospital: 1 ☐ Inpatie	nt 2 ER/O	utpatient	3 □ DOA Oth	or:		nce 6 Other (	Specify)			
Division of	ling Afte une	ation: T	27. Manner of Death  1★ Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injur (Month, Day	ry 28b.	Time of Injury	28c. Injur Work M 1		28d. Describe how					
DIVIS	al or Attend s after death Il Director:	Certification:	3	28e. Place of Inju building, etc	iry - At home, fa c. (Specify)	arm, stree	et, factory, office		28f. Location (Str City or Town,	eet and Number o State)	r Rural Route I	Number,		
	To the Hospital or within 24 hours after To the Funeral Director Completely filled in the complete of the comp	Medical C	29a. Certifier + Certifying Ph (Check only one) 2 Medical Exam	nysician: To the best on iner: On the basis of and manner sta	examination a	ge, death nd/or inve	occurred at the tirestigation, in my o	me, date and place	, and due to the carred at the time, da	ause(s) and manne ate and place, and	er as stated. due to the caus	se(s)		
	To the To the Comp	Me	29b. Signature and title of certifier	1			29c. Licens		1	d. Date signed (M		,		
			1 Ward	lovely	MO		D47	610	6	Derember	2920	18		
الر	5		30. Name and address of person who de David Tardio					nco Frode	rick MD	20678				
ابن	Sta		31. Date filed (Month, Day, Year) DEC 3	0 2008	s Signature		4		TION WILL	2010				
	Registr	ar	DEC 9	U LUUU	ENLIVE.	N.	ASSESSED OF THE PARTY OF THE PA	7						

			State of Maryland / Department of Health and N		/	2008	43312
	_		State RegistraMFND#10e, 19a/bperINF1/6/09, BW, MccCertificate of Death  1. Decedent's Name (First, Middle, Last)	2. Date of De	Reg. No.		3. Time of Death
	Physicia		Alan Robert Cohen	Month Decemb	Day	Year 5. 200	M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	Decem		County of Dea	
and the second			Montgomery General Hospital Olney  5 Social Security Number   6 Sex   7 Age (In vrs. last birthday)   If Under 1 Year   If Under 24 Hrs.	0 Data of Bir	M	ontgom	ery rthplace (State or Foreign
	Funeral Director		1 M 2 F Vrs Months Days Hours Min.	8. Date of Bir (Month, Da Jan 31		C	ountry)
			Usual Residence of Decedent	Jan 31	. 19	32   Ne	w York
	arylan show	'n	10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	he Ma	Director	Maryland Montgomery Silver Spring  10e. Street and Number 10f. Zip Code		10a Citiz	zen of What Co	
	with t		15300 Beaver Brook Ct, APT 2-F 20906		US		ournay.
	death	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Sp. 1f Yes, specify Cuban, Mexican, Puerto	ecify Yes or No		4. Race - Ame Black, Whit	
2	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Evolution or court by northful at	by Fu	1 □ Never Married 2 ☑ Married 1 ☑ Yes 2 □ No1 2 54 — 1 □ Yes 2 ☑ No Specify:	Tilean, etc.)		Specify:	
Ś	hours tural"		3 ☐ Widowed 4 ☐ Divorced Year or Dates: 1956  15. Decedent's Education 16a. Decedent's Usual Occupation		16b. Kir	nd of Business	White //Industry
2	in 72 in "na Madic	plet	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  (Give kind of work done during most of work life. DO NOT use retired)	ing			Department
7	d with	Completed	4 Administrator		of	Health	-
2	uld be filed withi Mental Hygiene. <b>arked other thar</b> a <b>tic event, than</b>	Be	17. Father's Name (First, Middle, Last)  18. Mother's Nam		Maiden S	Surname)	
<u> </u>	should be ind Mental i marked c imatic ev	욘	Saul Cohen Mary Di	amond	er City or	Town State	Zin Code 20906
<u> </u>	and 2 sho ealth and n 27 is ma		19a, Informant's Name/Belationship (Type. Rright) ESTELLE L. CONEN WITE  - Estelle 1. Cohen/Wife  19b. Mailing Address (Street and Number or Rui  Beaverbrook 15300 Beaver Brook Ct.	Δ <b>P</b> T 2	)_F	Silver	Spring MD
ָּט ב			20a. Method of Disposition 20b. Place of Disposition (Name of cemetery crematory or other place)	Date 2	20c. Lo	cation - City or	Town, State
ॗ	Pages ment of ant: If its ury or o		4 Donation 5 Other (Specify)  Judean Memorial Grdns Dec	30, 20	008	Olney.	MD
a E	permit. Page Department of Important: If any injury or once,		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hir	es-Rina	ıldi	Funera	1 Home
<b></b>	⊈0 <b>= 8 0</b>		11800 New Hampshire	<del></del>		r Spri	ng, MD 20904 Approximate
		, l	23a. Part 1. Enter the disease, fir complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.  Immediate Cause (Final		iresi,		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)  a.     PWWWOMLACAST   WWW   Due to (or as a consequence of):				
	Examiner		FCAMPROPAL DEILOTELIO	U			
	pi ii	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury				
)	xecute and Il-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last  C. ESPNESEACE CULL ELC  Due to or as a consequence of):				
2	rificate be executed ng physician and as the burial-transit		Sepsis				
00	tificating phy as the	ledical					
אַ מַ	eath certif attending for use as	hysician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy  1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy		2	3d. Date of de	olivery Day Year
5	the de:	ysici	1   Yes 2   No 9   Unknown   4   Pregnant at time of death 5   Other (specify)				24,
ŗ	ires that the de signed by the a I be detached t	0	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did 1	obacco u	se contribute t	to the cause of death?
corus,	quires an sigr uld be	ed by		1 🗆	Yes 2	2No 3□F	Probably 4 Unknown
2	aw requir as been s 2 should	Completed		24a. Was		24b. Were a	utopsy findings available completion of cause of
Č	The late har	ĕ			ormed?	death?	
2	di <b>ng Physician:</b> The law h. After this certificate has t funeral director, page 2 s	Be	25. Was case referred to medical examiner?	th (Check only o	one)		
5	ing Phys t. After this of funeral dir	Ŀ.		ome 5 Resi			ecify)
5	ding th. : After	tion	27. Manner of Death  1 Natural 5 Pending (Month, Day, Year)  2 Accident investigation  28a. Date of Injury (Month, Day, Year)  28b. Time of Injury Work?  1 Yes 2 No	Zod. Describe	non anjar	Gecurred	
2	Atter ector by the	ertification: T	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f, Location ( City or To			Rural Route Number,
5	ital or irs aftu ral Diu lled in	Cer					
	To the Hospital or Attending Physician: The law requires that the death certi within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Medical	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.				
	To the within To the comp	Me	29b. Signature and title of certifier 29c. License number		29d. Dat	e signed (Mon	nth, Day, Year)
	10		Me jum Hospitalist Doos 9414	~	12/0	25/8	
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Dr. RAKHMANIN 18101 Prince Philip D	r Oc	ney	MIC	20832
	Sta Registr		31. Date filed (Month, Day, Year)  DEC 3 1 2008  32. Registrar's Signature				
_							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Ruth Elaine CATZVA 31, 2008 December /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery 2201 Colston Drive #601 Silver Spring 8. Date of Birth (Month, Day, Year)
Dec. 27, 19 If Under 1 Year | If Under 24 H Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Min. Months Davs Hours 1 □ M 2 💢 F Maryland 97 Dec. 1911 Director 216-01-5687 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 10b. County 1 Yes 2 No Director Silver Spring Marvland Montgomery the 10g. Citizen of What Country? 10e. Street and Number death with "natural", or items 23a or 20910 United States 2201 Colston Drive #601 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 72 hours after 1 □ Never Married 2 □ Married 1 ☐ Yes 2 🔀 No Specify: white Specify Š 3 Widowed 4 □ Divorced Completed Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Federal filed within Elementary/Secondary (0-12) College (1-4or 5+) Clerk Typist the Government Pages 1 and 2 should be filed vent of Health and Mental Hygie ant: If item 27 is marked other t 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nathan Berman Sarah Marx ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2:
Department of Health ar
Important: If item 27 is
any injury or other trau 10104 Bell Inn Lane, Ellicott City, MD 21042 Gary Catzva, Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Lebanon Cemetery 01/04/09 Adelphi, MD 21. Signature of Furnal Service Licensee Torchinsky Hebrew Funeral Home 254 Carroll St., NW, Washington, DC 23a. Parti. Ener the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 20012 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acute Respiratory Failure **Physician** /Medical Due to (or as a consequence of) Examiner Chronic Anemia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Dementia and burial-trar Due to (or as a consequence of): death certificate be exec physician Depression Physician/Medical the, as nse s 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for t in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown þ signed by be detailed 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been si, page 2 should t Completed 24b. Were autopsy findings available prior to completion of cause of death?

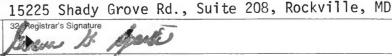
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1☐ Yes 2 No certificate 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 N Residence 6 Other (Specify) 1 ☐ Yes 2 💆 No 1 Inpatient 2 ER/Outpatient 3 DOA ٩ this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No ours after death.
neral Director: A death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital or 24 hours a 🕍 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 8,800 D 0063232

State Registrar

31. Date filed (Month, Day, Year) DEC 3 1 2008

Patricia Gomez, M.D.,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Maryland 21215-0036

3altimore,

Box 68760,

P.0.

Division or Vital Records,

Division of Vital Records, P.O. Box 68760,

		- Hegistrar				incate of	Douth		neg. No.	000	4001		
Physicia		1. Decedent's Name (First, Middle, L Clarence Washing						2. Date of E Month	Day Day er 22,	Year 2008	3. Time of Death 8:45 P <sup>M</sup>		
/Medic		4a. Facility Name (If not institution, g				4h. City Town	or Location of De		4c. County of Death				
Examin	er				. 2004		Montgomery						
		Montgomery Gener  5. Social Security Number 6.		t birthday)	Olney If Under 1 Year	If Under 24 H	s. 8. Date of E		y hplace <i>(State or Foreig</i>				
Funeral			1 X M 2 □ F		Yrs.	Months Days	Hours Mi	n. (Month, I	Day, Year)	Co	untry)		
Director		219-12-1927 Usual Residence of Decedent		93				Nov. 2	2, 191	.5	Maryland		
and w		10a. State 10b. County		10d. Inside City Limits									
laryl	ō				1 □Yes 2 XNo								
he N	ect	Maryland Frederick Monrovia  10e. Street and Number 10f. Zip Code 10g. 0											
ith t	흐	10e. Street and Number				10f. Zip Code			10g. Citizei	n of What Co	untry?		
ath v 23a	ra	12536 Fingerboar				21770			USA				
sme.	by Funeral Director	11. Marital Status	12. Was Decedent Armed Forces?		13.	Was Decedent of I If Yes, specify Cub	Hispanic Origin? an, Mexican, Pue	(Specify Yes or Nerto Rican, etc.)	lo- 14.	Race - Ame Black, White			
afte or i		1 Never Married 2 Married	If Yes, Give	No		1⊡Yes 2⊠No	Specify:		Sr	nonifu:			
inal"	d b	3 Widowed 4 Divorced	Year or Dates:							Whi			
72 h	Completed	15. Decedent's ( Specify only highest g	Education gra <i>d</i> e co <i>mpleted)</i>	1	(Give	dent's Usual Occu kind of work done	during most of w	orking		of Business/	•		
ithin han han	ם	Elementary/Secondary (0-12)	College (1-4or 5	·   _		DO NOT use retire	·				es Depart.		
ed w lygie lygie rt.		7		C	arper	iter - Wo				e Navy	7		
tal F d otl	Be	17. Father's Name (First, Middle, La.	31)				18. Mother's N	ame (First, Middi	e, Maiden Su	rname)			
Mer arke	၉	Albert William C	rum				Eva May	Burke					
2 sh and ls m aum		19a. Informant's Name/Relationship	(Type. Print)		19b. Mailir	ng Address (Street	and Number or i	Rural Route Num	ber, City or To	own, State, Z	(ip Code)		
and ealth n 27 ier tr		Wayne Crum, son				Stansbu		e, Monro	via, M	arylar	id 21770		
of H of H r oth		20a. Method of Disposition	ΠB	20b. Plac	e of Dispo	sition (Name of natory or other pla	ce)	Date	20c. Locat	tion - City or	Γown, State		
Pag nent int: I		1 X Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec				e Meth.	i	26/2008	Monro	ovia. I	Maryland		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evaluations is not the notified at once.	i	21. Signature of Funeral Service Lic	ensge								uneral Homo		
permi Depar Impo any Ir		XIIIII M	Dus			6401 Ridg					20872		
		23a. Part 1. Enter the disease, or co	mplications that caused	the death.						<i>y</i>	Approximate Interval Between		
Dhamisian		shock or heart failure. List on Immediate Cause (Final	y one cause on each lir	ne.							Interval Between Onset and Death		
Physician /Medical		disease or condition resulting in death)	a Metasta			e Cancer					Years		
Examiner			Due to (or as	a consequen	nce of):								
	<u></u>	Sequentially list conditions,	b	a consequen	oce of):								
ted 1sit	Ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	240 (0) 40	u oonocquen	100 01).								
xecu and I-tran	Examiner	that initiated events resulting in death) Last	c Due to (or as	nce of):				, .,					
be e													
eath certificate be executed attending physician and for use as the burial-transit	an/Medical	ži die die die die die die die die die di											
ding se as	Me	IF FEMALE:	23c. If yes, outcome	of pregnancy	v								
ath atten		23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Fetal de	eath 3	Ectopic pregnanc	су		230	<ol> <li>Date of deli</li> <li>Month</li> </ol>	very Day Year		
at the de l by the stached	/sic	4 DV - 4 Dreunant at title of death 5 Dotner (specify)									,		
hat ti	Physi	Part II. Other significant conditions	23e Did	Did tobacco use contribute to the cause of death?									
w requires that s been signed t should be deta	र्व	are in out of organization	continuating to doubt be	at not rooutin	ig iii aic ai	identying educe gi	on in arc i.		Yes 2 🛣 1				
requirement of the second of t	Completed						-	''_	jres z <u>un</u> i	10 3 FI	obably 4 Unknown		
law las b	ᇍ			***				24a. Wa	s an 2 opsy	24b. Were au	topsy findings available completion of cause of		
The ate the	్ర్ట								formed?	death? 1 □ Yes	_		
sician: The law certificate has t irector, page 2 s	Be	25. Was case referred to medical					26. Place of De	eath (Check only					
yslc iis ce direc	임	examiner? 1 ∐ Yes 2 🔯 No	Hospital:	ent 2 ER	l/Outpatien	t 3 DOA Oth	er: 4 🗆 Nursing	Home 5 ☐ Res	sidence 6	Other (Spec	cifv)		
g Ph		27. Manner of Death	28a. Date of Inju (Month, Da	iry 28	Bb. Time of Injury	28c. Inju Wor		T	how injury or				
ath.	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigati		y, 10u1/	,,		Yes 2 □ No						
Atte ecto by th	iţi	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	28e. Place of Inju	ury - At home	, farm, stre	eet, factory, office	-	28f. Location	(Street and N	lumber or Ru	ral Route Number,		
al or affe	Certification:	4 Difficiale	building, etc	c. (Specify)				City or 10	own, State)				
bour hour inera y fille		29a. Certifier 1 Certifying F	Physician: To the best	of my knowle	edge, death	occurred at the ti	ime, date and pla	ce, and due to th	e cause(s) ar	nd manner as	stated.		
e Ho e Fu e Fu	Medical	(Check only 2 ■ Medical Ex- one)	aminer: On the basis of and manner sta	f examinatior ated.	n and/or in	vestigation, in my	opinion, death oc	curred at the time	e, date and pla	ace, and due	to the cause(s)		
To the Hospital or Attending Physician: The law requires that the death within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the atter completely filled in by the funeral director, page 2 should be detached for unapplied to the funeral director.	Me	29b. Signature and title of certifier				29c. Licens	se number		29d. Date s	igned (Month	, Day, Year)		
78		) ( h: 1: 0.	end- 0			D/2/E2			Da = - 1		2009		
19)	ŀ	30. Name and address of person wh	Acompleted source of d	leath /Item 00	3a) (Time 1	D42452			Decemb	er 22,	2008		
9		(/ 0		·		,	#007	01.	V 3	1 00	000		
- 0~		Chitra Rajagopal 31. Date filed (Month, Day, Year)	, MU, 1811 32. Buểnistr	Price ar's Signature	Phil	.ip Drive	#32/,	Ulney,	Maryla:	nd 20	832		
Stat		DEC 2 9	2008	- I grid di	1 13	nones							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last 2. Date of Death 2.00 S Month **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** edical Polis a If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** 1□M 2**K**F Months Yrs. Director 2000 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If all influence I is miner must be notified at once. 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Be Completed by Funeral Director 360 1000 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21230 S (A Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian. 11. Marital Status 1 Never Married 2 Married Black, White, etc. □Yes 27No Yes, Give Baltimore, Maryland 21215-0036 Specify: \ 1 □Yes 27No Specify: 3 Widowed 4 Divorced かって Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middfle, Maiden Surname) ဥ 19a. Informant's Name/Relationship 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) (na)20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City of Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Atlantic Crematory 12/22/2008 Glen Burnie, Md 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hardesty Funeral Home, 12 Ridgely Ave. Annapolis, MD 21401, 21. Signature of Funeral Service License 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ZHR-1/min disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Be Completed by Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 2 No 1 □Yes 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ical Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DDA 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation 1 ☐Yes 2 ☐No within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29c. License number 29d. Date signed (Month, Day, Year) 32325 and address of person who completed cause of death (Item 23a) (Type, Print) MIDE 22. Registrar's Signature 2 2008 State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death **Physician** Helen Rita Coletta 18, December 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Fairfield Nursing Center Crownsville Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan. 26, 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** . 1917 Days Months Hours 1 □ M 2XX 033-09-8193 91 Jan. Massachusetts Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mertal Hygiene. ant: If Item 27 Is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, If "Medical Ex." in Item Intelled. 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Anne Arundel Annapolis Director 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21403 961 Breakwater Drive U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married ∐Yes 2∕CXNo If Yes, Give Year or Dates: 1 □Yes XXNo Specify: White **3** Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Seamstress Textiles 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Olisi Lombari Giusepna Iannazzi 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sheila Scarelli/daughter 961 Breakwater Drive Annapolis, Maryland 21403 permit. Pages 1 and 2 Department of Health Important: If Item 27 any injury or other troone. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Immaculate Conception 12/24/2008 Lawrence, Mass. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Brown cu Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) signed by the a d be detached for 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐Yes 2 **N**O 2 ANO 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 Yes 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated 29b. Signature and 29d. Date signed (Month, Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Registrar

Baltimore, Maryland 21215-0036

Box 68760.

P.O.

Division of Vital Records,

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death December 31, 2008 10:25P Marian Katherine Darnley 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Lonaconing Egle Nursing and Rehab Center Allegany If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months Days Hours Min. 1 □ M 2 🕱 F 214-05-7813 Maryland 100 January 13, 1908 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1XYes 2 No Allegany Lonaconing Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 57 Jackson Street 21539 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married 1 ☐Yes 2 No Specify Specify. 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clerk Gas 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) David Darnley Janet Lynn Hotchkiss 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 100 Dogwood Hill Court, Towson, Maryland, 21286 Alma McLean - Niece 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State January 02 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Cumberland Crematory 2009 Cumberland, Maryland 4 □ Donation 5 □ Other (Specify)

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

Director

Funeral

þ

Completed

Be

2

within 72 hours after death with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Nordical Exaction or other traumatic event, the Nordical Exaction

Baltimore, Maryland 21215-0036

Examiner The law requires that the death certificate be execute

the attending physician and the for use as the burial-tran Physician/Medical signed by t d be detach þ Completed certificate has page 2 Be Certification: To After this funeral within 24 hours after death

To the Funeral Director; completely filled in by the f

Natural

2 Accident

4 Homicide

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

JAN-6

3 ☐ Suicide

29a. Certifier

Medical

State

Registrar

5 Pending investigation

6 ☐ Could not be

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician;

21. Signature of Funeral Service Lic	ensee	22. Name and Address of Facility	Eichhorn	Eichhorn-McKenzie Funeral Home I				
+Snamoli	Wilholm,	8 East Main	Street Lonac	oning, MD 21539				
23a. Part 1. Enter the disease, or co shock, or heart failure. List on	omplications that caused the death. Do not ally one cause on each line.	ot enter the mode of dying, such as card		Approximate Interval Between				
Immediate Cause (Final disease or condition resulting in death)	a	Syn drops		Onset and Death				
Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin, Cause (Disease or injury	b	r):						
that initiated events resulting in death) Last	c	):						
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 XNo 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year				
Part II. Other significant conditions	s contributing to death but not resulting in t	the underlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death?				
Comme	Arty hosense	Demit of	_ 1 □ Yes	2 No 3 Probably 4 Unknown				
			24a. Was an autopsy performed?					
25. Was case referred to medical examiner?			eath (Check only one)					
1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outp	patient 3 DOA Other: Nursing	Home 5 ☐ Residence	6 ☐ Other (Specify)				
27. Manner of Death  TANatural 5 ☐ Pending	28a. Date of Injury 28b. Til		28d. Describe how in					

1 ☐ Yes 2 ☐ No

TG-CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

02124

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

**ORIGINAL** 

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Items 23b, 25 per me, 888, 02/25/09dhb Reg. No. for State Registrar Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) <sup>Day</sup> 24 Month **Physician** 2008 Carolyn Helen DiMaggio December 7:40 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number, Examiner Carrol1 Westminster Carroll Hospital Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Nov 3, 1923 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** Hours Months Days 1 □ M 2 3 F Maryland Director 85 <u> 217-14-6737</u> Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Mudon Event har mast be notified at once. 10a. State 10b. County 1 ☐ Yes 2X No Funeral Director Finksburg Maryland Carroll 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21048 USA 143 Lassiter Circle 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 20 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Completed by Specify: 3 Widowed 4 □ Divorced White Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Westinghouse <u> Assembly Line worker</u> 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph DiPietro Frances Sartino မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Reisterstown, MD 21136 3514 Juneberry Ct. <u>Joseph DiMaggio, Sr.</u> 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD Veterans Cemetery 1/5/2009 Garrison, Maryland 21. Signature of Funeral Service Licenses Printer Arthrefally Home and Chapel, P.A. V 412 Washington Road Westminster, MD 21157 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 50 Physician disease or condition resulting in death) /Medical Abdominal Surgery for Acute and Due to (or s a consequence of): Examiner Chronic Cholecystitis if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or) Examiner requires that the death certificate be executed attending physician and for use as the burial-tran CERTIFICA Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Year Month Day 5 Other (specify) ⊒Yes 2. No signed by the a Ö 9 Unknown 9 Unknown ₫. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has bage 2 s autopsy performed certificate 1 □Yes 2 PNo 1 🗌 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28h Time of 28d. Describe how injury occurred To the Hospital or Attending Pwithin 24 hours after death.

To the Funeral Director: After t completely filled in by the funera 28c. Injury at Work? After Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier December 24, 2008

DHMH 17 Rev 1/2001

Registrar

20

Westminster, MD

21157

200 Memorial Avenue

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Eid Almutairy, MD
31. Date filed (Month, Day, Year)

DEC 2 9 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2 0 0 8 1. Decedent's Name (First, Middle, Last) 2. Date of Death December 27,2008 **Physician** Thomas F. Day 6:50P. M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bowie Assisted Living Bowie Prince George's 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb. 4, 1917 6. Sex Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 XM 2 ☐ F New York 91 275-01-6718 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits Maryland Prince George's Bowie Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12001 Lanham Severn Road 20720 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1∑1 Yes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Ď 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Non-Commissioned Officer U.S. Air Force 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas Day Edna Cuer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Allen T. Day -son 5076 Lerch Drive Shady Side, Maryland 20764 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Fort Lincoln Cemetery 1/3/2009 Brentwood, Maryland 21. Signature of Funeral Service Licenses Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 Donald U 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Sepsis /Medical Due to (or as a consequence of): Examiner Aspiration Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed Exami Dementia attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FFMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death signed by the a 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 XNo 24a. Was an certificate has birector, page 2 s autopsy performed? Yes 2 X No 1□ Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other:  $_{4}\square$  Nursing Home  $_{5}\square$  Residence  $_{6}X$ 1Other (Assisted Lvng 1 ☐ Yes 2 X No P 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury 28h Time of 28d. Describe how injury occurred Certification: (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident letely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide TX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 24 within 24

To the F

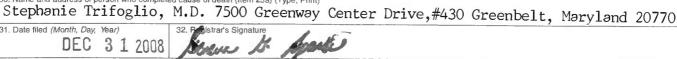
complete and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

3+1

Registra DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year) 3 1 2008



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

037934

December 29, 2008

Registrar

			1 - For State Registrar  1. Decedent's Name (First, N.	liddlo Las	State of Ma	ai yiai k		ertifica				2. Date of De	Reg. N	0.0	0.8	4 3 3. Time	321				
	hysicia		Dorothy Stew		*							Month Decem	D	19. 2	Year 2008		:10a <sup>M</sup>				
~~	/Medic xamin		4a. Facility Name (If not instit	ution, give	street and number)			4b. City	, Town, or	r Location	of Death	5000		c. County of			rou				
april .			Sunrise Assi					1,,,,,,,		napo]					ne Ar						
	neral ector		5. Social Security Number 150–09–8114			e (In yrs. la 93	ast birthda Yrs.	Months	Pr 1 Year Days	If Under Hours	Min.	8. Date of Bi (Month, D Nov • 0			9. Birthpl Count Mary		or Foreign				
Maryland	ifed at	tor	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location Severna Park										10d. Inside City Limits 1 ∐Yes 2 🛣 No								
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mendia Hyglene.  Department of Health and Mendia Hyglene.  Department of Health and Mendia Hyglene.  Department of Hyglene 1 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner rulet by notified at once.		Funeral Director	10e. Street and Number 202 Pine Ave	nue			****	10f. Z	p Code 211	46			10g. C	J. Citizen of What Country? USA							
at y fail of x 1 x 1 2 - 0000 on should be filed within 72 hours after death with the Maryland and Mental Hygiene.	al", or items	by	11. Marital Status 1 ☐ Never Married 2☐ 3🌠 Widowed 4 ☐ Divo		12. Was Decedent I Armed Forces? 1Yes 2XN If Yes, Give Year or Dates:	]Yes 2. MNo es, Give 1 □ Yes 2. No Specify:						city Yes or No Rican, etc.)	0-		- America , White, e Wh:						
rithin 72 ho	han "natuı e Medieni	Completed	(Specify only h	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)						16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)							16b. Kind of Business/Industry				
filed w Hygie	ther th	Col	17. Father's Name (First, Mic	Idle, Last)	2		.15	ookke	eber.	18. Moth	er's Name	(First, Middle		Finand en <i>Surname</i>							
id be	rked o tic eve	To Be	Paul Grisel									t Home:			,						
2 shou	is ma rauma	_	19a. Informant's Name/Rela				1					Route Numb					27042				
1 and Health	tem 27 other t		20a. Method of Disposition	ewar	L/ SOII	20b. PI					_	nue #		MONTC Location - 0			07042				
permit. Pages 1 Department of H	rtant: If it njury or c		1 ☐ Burial 2 ☐ Cremat 4 ☐ Donation 5 ☐ Othe 21. Signature of Funeral Ser	er (Specify	<i>'</i> )	Ati		sposition (Na rematory or CCPCII	TJC	i	Dec.	08		en Bu							
perm Depa	any ir		Allon,	no	ZAL		14	190 GC	V . K	TICIT	e nwy	A. Seve	rna	Park Park		2114	0				
Phys	sician		23a. Part 1. Enter the diseas shock, or heart failure. Immediate Cause (Final disease or condition	e, or comp List only	olications that caused one cause on each li	96	lia.		de of dyir	ng, such as	s cardiac o	r respiratory a	arrest,			Approxima Interval B Onset and	ate etween I Death				
	edical miner		resulting in death)		Due to (or as	a consequ	ence of):		11.	1000-1											
uted	d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	₹	Due to (or as	a consequ	ence of):							_							
tificate be executed	ng physician and as the burial-transit	edical Exa	resulting in death) Last  Due to (or as a consequence of):  d.																		
To the Hospital or Attending Physician: The law requires that the death certification of the hours after death.	rector: After this certificate has been signed by the attending pl by the funeral director, page 2 should be detached for use as the	sician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?   1 □ Yes 2 ☑ No   23c. If yes, outcome of pregnancy   1 □ Live birth 2 □ Fetal death   3 □ Ectopic pregnancy   4 □ Pregnant at time of death   5 □ Other (specify) □ □   1 □ No   1 □							у	-			23d. Date Mon	of deliver	ry Day	Year				
aw requires that I	n signed by Id be deta	d by Phys	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I.											death? Unknown							
The law rec	ite has bee iage 2 shou	Completed					0					_ "	psy ormed?	pr	lere autoprior to coneath?	pletion of	s available cause of				
ian:	ctor, p	Be C	25. Was case referred to me examiner?	dical						26. Plac	e of Death	1 ☐ Yes (Check only	2 One)	1		ZLINO	4. 1.				
ng Physic	fter this or ineral dire	٦	1 Yes 2 No  27. Manner of Death  1 Natural 5 Pe	ending	Hospital: 1 ☐ Inpatie  28a. Date of Inju (Month, Da)	ry	ER/Outpat 28b. Time Injur	tient 3 🗆 🗅	Oth 28c. Injur Worl	y at		ne 5 Res		6 Othe		ASSI.	ving				
or Attending	Director: A	Certification:	2 Accident in 3 Suicide 6 Co	estigation ould not be termined		ury - At hor c. (Specify	me, farm,	street, facto		Yes 2		8f. Location (	Street a	and Numbe	r or Rural	Route Nu	mber,				
e Hospital 24 hours	<b>To the Funeral Dlı</b> completely filled in	Medical Ce	29a. Certifier Cer (Check only 2 Mec	tifying Pi	ysician: To the best on the basis of and manner sta	f examinat	wledge, de ion and/or	eath occurre r investigation	d at the ti	me, date a	and place, a ath occurre	and due to the	e cause , date a	(s) and mai	nner as stand	ated. the cause	(s)				
To the within	<b>Го th</b> сощр	Me	29b. Signature and title of ce	rtire )				25	9c. Licens	e number			29d. D	Date signed	(Month, E	ay, Year)					
			•	10					D	5707	28			12-	27-0	280					
741	2		Aditus Chor	rson who	completed cause of d	•			veni	e H	231	Anno	200	ils v	AN	2314	tal				
MI	Sta	te	31. Date filed (Month, Day,		32. Registra			1	, ,	v 1 '	- (	7 - 1 1 10	1	1	. 10		,01				

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	Otato or Ma		ertificate of			eg. No. 2008	43322
Г			1. Decedent's Name (First, Middl	e, Last)				2. Date of Deat		3. Time of Death
	Physici /Medio		Claudette	Viola	E	persole		Decemb	Day Year	1119 am
and the second	Examin		4a. Facility Name (If not institution	n, give street and number)		4b. City, Town, o	or Location of Deat	th	4c. County of Dear	~
and the			Washington Cou	<u> </u>		Hagerst			Washing	
1	Funeral		5. Social Security Number	6. Sex 7. Age	(In yrs. last birthda	Months Days	If Under 24 Hrs Hours Min.		Year) 9. Bir	thplace (State or Foreign ountry)
	Director		214-54-0599 Usual Residence of Decedent		59 Yrs.			Sept. 24	4, 1949 Ma	aryland
	and		10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	be filed within 72 hours after death with the Maryland ital Hygiene. id other than "natural", or items 23a or 28a-f show event, the Medical Enarting must be notified.	ō	MD Wash	ington	Hannah					1 ∐Yes 2 X No
		Director	10e. Street and Number	Ington	Hagerst	10f. Zip Code		11	0g. Citizen of What Co	puntry?
	3a or		1201 Rabbit Cou	rt		21740			U.S.A.	•
	ms 2	Funeral	11. Marital Status	12. Was Decedent E	ver in U.S. 1	3. Was Decedent of I	Hispanic Origin? (S	Specify Yes or No-	14. Race - Ame	
9	after or ite		1 ☐ Never Married 2 ☑ Man		to Rican, etc.)	Black, White	e, etc.			
93	ral",	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 □Yes 2 <b>X</b> No	Specify:		Specify: Wh	ite
21215-0036	72 h	Completed		t's Education st grade completed)	16a. De	cedent's Usual Occu ve kind of work done b. DO NOT use retire	pation during most of wo	rkina	16b. Kind of Business/	Industry
121	within iene. • than	ם	Elementary/Secondary (0-12)	College (1-4or 5+	)		•			
2	filed v I Hygie other t ent, in		17. Father's Name (First, Middle,	l act)	ועו	ect Care		me (First, Middle, N	Nursing	
anc	ntal l ed ol	Be		Lasty			}	,	,	
Maryland	2 should be and Mental is marked craumatic ever	မ	Claude Edwards  19a. Informant's Name/Relations	hin /Time Drint)	10h Ma	ilina Address (Ctrost		leanor Hu		7-0-4-)
Ma	d2s than 7 is trau		Ralph L. Eberso			. Rabbit C			; City or Town, State, 2	•
Ġ,	1 an Heal em 2		20a. Method of Disposition	Jie, Ji./nusb					MD 21740 20c. Location - City or	
altimore,	ages ant of t: If it		1 🖾 Burial 2 ☐ Cremation		1	position (Name of rematory or other pla			Hagerstown	,
i	artme		4 ☐ Donation 5 ☐ Other (S		kest nav	ven Cemete			Funeral C	•
Ba	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evone.		21. Signature of Fullerial Service						erstown, M	
			23a. Part 1. Enter the disease, or	complications that caused to	he death. Do not					Annroximate
	Dhusisian		shock, or heart failure. List Immediate Cause (Final	only one cause on each line	1.1.4	ie a		1		Interval Between Onset and Death
;	Physician /Medical		disease or condition resulting in death)	a. Chronic	consequence of):	white p	Vince	O ISEASC		YEARS
	Examiner			Due to (or as a	consequence or).		U			
		ē	Sequentially list conditions, it any, reading to immediate cause. Enter Underlying Cause (Disease or injury	b. — Due to (or as a	consequence of).					
	cutec nd ransit	Examiner	Cause (Disease or injury that initiated events	G.						
oʻ	e exe an ar rial-t		resulting in death) Last	Due to (or as a	consequence of):					
68760,	rtificate be executed ng physician and as the burial-transit	Medical		d						
		Med	IF FEMALE:		7.5	Tier				
Box	eath ce attendir for use	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of	Petal death	B ☐ Ectopic pregnanc	су		23d. Date of del Month	
о -	Attending Physician: The law requires that the death ce redors the actions that After this certificate has been signed by the attendiby the funeral director, page 2 should be detached for use	Physician/	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at 9 ☐ Unknown	time of death	5 ☐ Other (specify) _			World	Day Year
σ.	hat the		Part II. Other significant condition	ons contributing to death but	not resulting in the	underlying cause giv	ven in Part I	23e Did tob	acco use contribute to	the cause of death?
ds,	signe signe	b	, and an entire engineering	one commissing to dodn't but	The researching in the	andonying oddoo gri	on are a		,	obably 4 ☐ Unknown
Š	w requir s been s should	etec								
ž	has has	Completed					<del> </del>	24a. Was an autopsy perform	y prior to o	topsy findings available completion of cause of
<u></u>	i <b>ician:</b> Th certificate rector, pag		05.14					1 □ Yes 2		2 □ No
<b>#</b>	ysician: The iis certificate h director, page	Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:		iont 3 🗆 DOA Oth	or:	ath (Check only one	<del></del>	
Division of Vital Records,	Phys er this eral dii	Ę	27. Manuar of Death	28a. Date of Injury	/ 28b. Time	IEIIL 3 L DOA	4 LI Nursing F	lome 5 ☐ Resider	nce 6 Other (Spec	oify)
e O	th. th. Afte fune	ţ	1	g (Month, Day,	Year) Injury	/ Wor	ḱ? Yes 2 □ No	233. 233	a anjury occurred	
isi	Atter r dea ector by the	lica	3 ☐ Suicide 6 ☐ Could	not be 28e. Place of Injur	y At home, farm,	street, factory, office		28f. Location (Str	reet and Number or Ru	ıral Route Number,
_	2 P = C	Certification: To	4 ☐ Homicide determ	building, etc.	(Specity)			City or Town,	, State)	
	ospit hours inera ly fille	Sal	29a. Certifier 1 Certifyir	g Physician: To the best of	my knowledge, de	ath occurred at the ti	me, date and plac	e, and due to the ca	ause(s) and manner as	stated.
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	one)	Examiner: On the basis of and manner stat	ed.	investigation, in my	opinion, death occi	urred at the time, da	ate and place, and due	to the cause(s)
	North Con	Σ	29b. Signature and title of certifie			29c. Licens		7	d. Date signed (Monti	n, Day, Year)
			Mitten	ela Phys	leier		6783		Pecky 50,	wob
A	H-3		30. Name and address of person	who completed cause of de	ath (Item 23a) (Typ	e, Print)		1 Camp	C Pal	HUGRISTON
$\smile$			31 Date filed (Month Day Year)	PHW W17 7	- M ()	MINA	ieallas	lamp	2651491.	JMD
	Sta Registr		31. Date filed (Month, Day Year)  JAN 0 5	32. Registra	-	back				21742
			JAN U J	LUUJ / Lucu	U 1. 14	Tark.				

			For State Registrer	State of Maryland		artment of F			giene 0 0 8	3 43323				
	<b>-</b>		1. Decedent's Name (First, Middle, Las	t)				2. Date of Dea Month	Day Yes	3. Time of Death				
	Physicia /Medic		Thelma Ruth Ed	elblute				Decem	16-ex 24,2	MASO: 8 800				
į.	Examin	er	4a. Facility Name (If not institution, give	1		4b. City, Town, o	r Location of Deat	110	4c. County of De	•				
			5. Social Security Number 6. So		ast birthday)	If Under 1 Year	If Under 24 Hrs	8. Date of Birth	10017	Orthologe (State or Foreign				
	Funeral Director			□ M 21XF 91	Yrs.	Months Days	Hours Min.	Dec. 09	· Year)	country) ennsylvania				
	D		Usual Residence of Decedent	140.00										
	arylar show	_	10a. State 10b. County MD Baltimo		, Town or Lo atonsv				10d. Inside City Lin 1 ☐ Yes 21又					
	28a-f	ecto	10e. Street and Number	ie c	aconsv	10f. Zip Code			log. Citizen of What					
	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or items 23a or 28a-f show event. The Madical Expoliter front be notified at	Funeral Director	715 Maiden Choic	e Lane, PV 318			228	'	USA	555my1				
	ne 23	era	11. Marital Status	12. Was Decedent Ever in U.S	6. 13.	Was Decedent of H	lispanic Origin? (S	Specify Yes or No- to Rican, etc.)	14. Race - A	merican Indian,				
9	or Ite	F	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give		1 Tes, specify Cubi 1 □ Yes 21∑ No	Specify:	to rican, etc.)	Black, W	White				
5-0036	ural',	d by	3 Widowed 4 □ Divorced	Year or Dates:										
2	n 72 t	Completed	15. Decedent's Ec (Specify only highest gra		(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of wo	rking	16b. Kind of Busine	ss/Industry				
2121	within lene. than	E G	Elementary/Secondary (0-12)	College (1-4or 5+) 4		istered i			Hospit	als				
	Hygie other	Be C	17. Father's Name (First, Middle, Last)	-				me (First, Middle,						
<u>lar</u>		To B	Ira Gates				Bessie	Crissmar	າ					
Maryland	17.5		19a. Informant's Name/Relationship (Christine Cooper						r, City or Town, State , Texas 75					
altimore,	of Heal		20a. Method of Disposition	20b. Pl	ace of Dispo	sition (Name of natory or other pla	(a) Dec	16	20c. Location - City					
E	Page nent c ant: If ury or		t ☐ Burial 2 12 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Hemoval from State ALL	ancie	Cremator LL	Č'	2008′	Glen Burn	ie, MD				
Balt	permit. Pages 1 en Depertment of Heal Important: if Item 2 eny Injury or other once.		21. Signature of uneral Service Len	1 A Non	9 4	ame and Address Franco 95 Gov.	& Sons, Ritchie	P.A. Seve Hwy, Seve	erna Park erna Park,	Funeral Home MD 21146				
			23 art1. hter the disease, or comshock, in heart failure. List only	olications that caused the death one cause on each line.	. Do not ent	er the mode of dyir	ng, such as cardia	c or respiratory arr	rest,	Approximate Interval Between				
1	Pnysician	- 2	mmediate cause (Final disease of condition resulting in death)	. Atheros	cler	otic t	teart	Dise	ase	Onset and Death				
	/Medical Examiner	1	resulting in death)	Due to (or as a consequ			, , , , ,			1				
		<u></u>	Sequentially list conditions, if any, reading to immediate	b. — Due to (or as a consequ	ionae of):									
1	nsit	Examiner	Cause (Disease or injury											
Ć.	execu in and ial-tra	Еха	that initiated events resulting in death) Last	C. Due to (or as a consequ	ence of):									
8760,	Physician: The law requires that the death certificate be executed this certificate has been signed by the ettending physicien and rall director, page 2 should be detached for use as the burial-transit	icai		. d.										
	ng ph	ed l	IF FEMALE:											
P.O. Box 6	eath certific ettending p i for use as i	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnar 1 Live birth 2 Fetal	death 3[	Ectopic pregnanc	у		23d. Date of Month	delivery Day Year				
<u>.</u>	the e	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of de 9□ Unknown	eath 5	Other (specify) _								
	res that the de igned by the e be detached f		Part II. Other significant conditions of	ontributing to death but not resu	Iting in the u	nderlying cause giv	ven in Part I.	23e. Did to	bacco use contribute	to the cause of death?				
rds	quires n sign	d by	Chronic	obstructi	ve	lung		1 🗆 Y	es 2 No 3	Probably 4 Unknown				
000	aw require s been si 2 should b	Completed	disea	us-e		7		24a. Was a		autopsy findings available to completion of cause of				
æ	The is	E						autop: perfor		?				
Division of Vital Records,	Physician: The lav this certificete has al director, page 2	Bec	25. Was case referred to medical examiner?					ath (Check only or						
2	hysic this co	ဥ	1 Yes 2 No		ER/Outpatier	IL 3LI DOA	<del></del>	1	lence 6 Other (S	pecify)				
Ĕ	After I	lon:	27. Manner of Death 1 ☐Natural 5 ☐ Pending	(Month, Day Yeer)	28b. Time o Injury	Wo	ryat rk? ]Yes 2 □ No	28d. Describe n	ow injury occurred					
isi	Attending ir death. ector: After by the fune	licat	2 Accident investigation 3 Suicide 6 Could not b		me, farm, st		1163 2 110	28f. Location (S	Street and Number or	Rural Route Number,				
≧	after after Direction of in by	Certification:	4 Homicide determined	building, etc. (Specify	)	, <b>,</b>		City or Tow	m, State)					
	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical C	(Check only 2 Medical Exar	y initian: To the best of my knowniner: On the basis of examinat										
	the H	Medi	one) 29b. Signature and title of certifier	and manner stated.	-	29c. Licens			29d. Date signed (Me	•				
	To To	_	11-00 SL.	A Na		1								
			30. Name and address of person who	completed cause of death (Item	23a) (Type	Print	t700°	1	recemb	361-74,7000				
(	D6 /4		Phillip St	-one 711	A A	uden 9	hoice	Lane	Baltimo	re, MD 21228				
		ate	31. Date filed (Month, Dal, Year) DEC 2 9	2009 32. Registrar's Signal		parked		/		,				
	Regist	rar	DEC 2 9	LUUU Meneura	P. 1	acres								

			For State Registrar	State of	f Marylan			it of He e of D		and M	•	giene Reg. No				
			Decedent's Name (First, Middle, Las	t)							2. Date of De	ath	200	8	3. Time of Ceasin	4
	Physicia /Medic		Charles Henry I	Foote						T,	ecembe	er .	Ž3 2Č	80	12:00P N	Λ
	Examin		4a. Facility Name (If not institution, give			Town, or L				4c						
e de		4	Washington Adve	Vashington Adventist Hospital     Tak       Social Security Number     6. Sex     7. Age (In yrs. last birthday)     If Under 1									ontgo		Y lace (State or Foreig	an
	Funeral Director			<b>X</b> M 2□ F		57 Yrs.	Months		Hours	Min.	8. Date of Bir Aug 9				land	μι
	and w		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location											1	0d. Inside City Limit	s
	Maryla	Ď	Maryland Calver	t	1	wings								1 □Yes 2 No		
	r 28a	irec	10e. Street and Number				10f. Zip	10f. Zip Code					10g. Citizen of What Country?			
	th with	alD	2030 Horace Was	rd Rd.			2	20736					USA			
0030	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time Z7 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Maryleal Experience in set be retified a once.	by Funeral Directo	11. Marital Status  1 ☐ Never Married 24 Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Dece Armed Fo 1 XYes If Yes, Giv Year or D	2 No	If	Vas Dece Yes, spe Yes	cify Cuban	panic Ori , Mexican Specify:	gin? (Spe , Puerto	ecify Yes or No Rican, etc.)	-	14. Race - Black, \ Specify:	Vhite, 6	etc.	
5	2 hou	ted	15. Decedent's Ed	ucation	1977	16a. Deced	lent's Usu	al Occupat	ion			16b. K	ind of Busin	ess/Ind	dustry	
2	Ithin 7 ne. nan "n	Completed	(Specify only highest gra	College (1	-4or 5+)			rk done du se retired)		or worki	ng					
7	lled w Hygier ther th		12th 17. Father's Name (First, Middle, Last)	0		Co	nstr	ucti		r's Name	(First, Middle,		•	ra	ndell	
an	id be f ental ked or ic eve	To Be	Charles H. Foo								Tongu		ournamoy			
ary	shoul and M s mar	-	19a. Informant's Name/Relationship (7			19b. Mailin	g Address				al Route Numb		or Town, Sta	ite, Zip	Code)	
Ξ. -:`	and 2 ealth n 27 i	Į	Tracey Foote(W	ife)		2030									20736	
baltimore	Pages 1 tment of H tant: If iter jury or oth		20a. Method of Disposition  1 [XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  Maryland Veteran Jan. 5 2009Crownsv									7 <b>i</b> 1.	ille, Md.			
pal	permit Depar Impor any in once.	21. Signature of Funeral Service Licensee  7. Mame F. A. Griff Ons Mortuary, 821 West St. Annapolis, Md.  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,											_			
1	Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)		aused the death ach line.  1900 (or a consequiab effection)						or respiratory a	rrest,			Approximate Interval Between Onset and Death	
	/Medical Examiner		resulting in death)	Due to	or a consequence of a box of a	ence of):	elli.	hes		ै					Vvc	
	n +	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to	or as a consequ	ience of):		1000							<i>/</i> · · ·	
	ecuted and -transi	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):													
8/60,	icate be executed physician and the burial-transit	dical E	d.													
	tificate ig phy as the			. u							· · · · · · · · · · · · · · · · · · ·					
J. BOX	To the Hospital or Attending Physician: The law requires that the death certification 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending to the Funeral Director. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 5 □ Other (specify)  Mon  23d. Date  4 □ Pregnant at time of death 5 □ Other (specify)								23d. Date o Month					
Ţ.	hat th		9 ☐ Unknown  Part II. Other significant conditions o	ontributing to de	eath but not resu	ıltina in the un	nderlvina o	ause giver	in Part I.		23e. Did t	obacco	use contribu	te to th	ne cause of death?	
ecords,	uires t n signe ld be o	d by	chranic leet			_	,9	g			1 🗆 `	Yes 2	<b>™</b> No 3[	☐ Prob	ably 4 🗌 Unknow	'n
င္တ	s beer	olete		0							24a. Was		24b. We	e auto	psy findings availab	e
¥	The la ate ha page 2	Completed						-			autor perfo 1 □ Yes	osy rmed? 2 <b>X</b> No	dea	th?	npletion of cause of 2 <b>₩</b> No	
VITAI	Physician: r this certific ral director,	Be (	25. Was case referred to medical examiner?					-		of Death	(Check only o	-			/	
5	Physi this c	၉	1 ☐ Yes 2 🕅 No	Hospital: 1 X	Inpatient 2	ER/Outpatien 28b. Time of		Other 28c. Injury	4 🗀 NU		me 5 Resi			Specif.	y)	
Sion	ding th. : After funer	tion	1 Natural 5 Pending 2 Accident investigation	(Mon	th, Day, Year)	Injury	м	Work?	es 2∐I		zou. Describe i	iow inju	ry occurred			
DIVISI	al or Atter s after dea I Director d in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place	of Injury - At ho ng, etc. (Specify	me, farm, stre	eet, factor	y, office			28f. Location ( City or To	Street ai vn, State	nd Number ( e)	or Rura	l Route Number,	
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	niner: On the b												
	To t To t	Σ	29b. Signature and title of certifier	820	rus			i. License	601	,		29d. Date signed (Month, Day, Year) December 23, 20			13,2008	
24	104			BRILL	se of death (Item	23a) (Type, F <b>790</b> /	Print) Wal	de A	e T	aku	na Pa	vle	us.	20	712	
	Sta	te ar	31. Date filed (Month, Day, Year) DEC 2 9 2		gistrar's Signa	ture		,								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 43325 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) December 26, 2008 **Physician** 2:47 P M Henrietta Cecelia Ruymen Fuller /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Howard Elternhaus Assisted Living Dayton If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Nov 1915 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days 1 □ M 2 □ XF New Jersev 93 144-09-2561 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Waden Expriner must be notified a once. Director 1 ☐Yes 2 No N.J Bayville 0cean 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 08721 30 Sand Bar Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 ☑ If Yes, Give Year or Dates: 2 ZNO 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No Specify: White þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ida Kaufman Henry J. S. Ruymen ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15620 Evesham Place Silver Spring, MD 20905 Art Fuller/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【ACremation 3 ☐ Removal from State W. Arundel Crematory 12/31/08 Odenton, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service. Going Thomes Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): burial-tran Due to (or as a consequence of): certificate has been signed by the attending physician rector, page 2 should be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not regulting in the underlying cause given in Part I, 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐Yes 2 ☐No 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Asst. Living 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural n 24 hours after death.

e Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 □Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

altimore, Maryland 21215-0036

completely

To the within 2.

After this

State

Registrar

Medical

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

December 29, 2008

Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

31. Date filed (Month, Day, Year)

DEC 3 0

29b. Signature and title of certifier

29a Certifier

(Check only one)

egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Flizabeth 09 10AM Dec 2008 21 /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** olumbia Somerford Assisted Living Howard 5. Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🛣 F Months 218-16-6705 New York Director 85 5,1923 Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at Director 1 ∏Yes 2 X No Maryland Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8220 Snowden River Parkway 21045 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene.

Important: If them 27 is marked other than "natural", or item any injury or other traumatic event, the Mental Proper Black White, etc. 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 ☐ Yes 2 🛣 No Specify: White þ Specify 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jay Edward Overton Selina McCormick ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Robert Flaherty/Son 4 Rumford Drive, #302, Catonsville, MD 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Our Lady Of Good Counsel 12/23/2008 Secretary, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Zeller Funeral Home, P. O. Box 207
106 Main Street, East New Market, MD 21631 21. Signature of Juneral Service Licens 27a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) meris **Physician** 4 years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Exami Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 ☐ Other (specify) 4 ☐ Pregnant at time of death 1 ☐ Yes 2 🗖 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? mellitus Be Completed by Diabetes 1 ☐ Yes 2 📈 No 3 ☐ Probably 4 🗀 Unknown arkinsons 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 **X** No 1 □Yes 2 **X** No 1 TYes funeral director, 25. Was case referred to medical examiner? Assisted 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Cother (Specify) Hospital: 1 Yes 2 XNo Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

or Attending Physician: The law requires that the death certificate be executed Box 68760. P.O. Records, Vital of Division 24 hours after death. Funeral Director: A filled in by Hospital

Baltimore. Maryland 21215-0036

Medical

completely

within 2

29a. Certifier

(Check only one)

29b. Signature and title of certifier

DEC 3 0

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Harry Li 8600 Snowden River Prwy #301, Columbia, MD 21045 Registrar's Signature



M.D.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

56531

29d. Date signed (Month, Day, Year)

Dec 23, 2008

State of Maryland / Department of Health and Mental Hygien 2008 43327 For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** December 22, 2008 Gladys Isabel Frantz 9:38 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Garrett Garrett County Memorial Hospital Oakland If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Mar 17, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□M 2₩F 95 214-42-0566 Maryland Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or iteme 23a or 28a-f ehow adical Examiner must be notified at 1 ☐ Yes 2 No Friendsville MD Garrett Director 10e. Street and Number 10g. Citizen of What Country? 10f, Zip Code 21531 USA 3583 Blooming Rose Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 white 1 ☐ Yes 2 🛣 No Specify þ 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry The Me Elementary/Secondary (0-12) 7 th College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be Walter Franklin Humberson Alice Estella Umbel 27 is marked traumatice 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, important: if item 27 is rent july or other traum. 3609 Blooming Rose Rd., Friendsville, MD 21531 Thelma J. Humberson/daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Blooming Rose CEm Dec 28, 2008 4 ☐ Donation 5 ☐ Other (Specify) Friendsville, MD 22. Name and Address of Facility Newman Funeral Homes, P.A. 21. Signature of Funeral Service License 179 Miller St., Box 275, Grantsville, MD 21536 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Due to (or asia conserve Immediate Cause (Final disease or condition resulting in death) **Physician** ariest /Medical Examiner Crosho rea Sequentially list conditions, if any, loading to in incident cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physicien and s the burial-transit Due to (or as a consequence of) Box 68760 Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal de 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy õ in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23e. Did tobacco use contribute to the cause of death? δ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? certificete has b irector, page 2 sl autopsy performed? 1 Yes 1☐ Yes 2 100 Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death | Check only one examiner Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No. 2 ER/Outpatient 3 □ DOA this Certification: 27. Manner of Death 28a, Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 12/22/08 the 6 Could not be determined 3 Suicide At nome, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At non building, etc. (Specify) filled in by 4 Homicide within 24 hours e To the Funerel C completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier To the 29b. Signature a 29c. License number 29d. Date signed (Month, Dev. Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D., 251 N. 4th st., Oakland, MD Kichard Perry 31. Date filed (Month, Day, Year) 32. Registrar's Signature 2009 parka Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 For State Registrar Amended #18perFH FCHD, KS 12/30768 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2008 Billie Zoe Fox December 11:35 A M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Frederick Memorial Hospital Frederick Frederick 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 👽 F Months Davs Hours Min 212-50-7796 Director 62 Oct. 10, 1946 West Virginia Usual Residence of Decedent the Maryland 10c. City, Town or Location 28a-f show 10d. Inside City Limits ir than "natural", or items 23a or 28a-f shov the Medical Examinar must be notified at Frederick Director Maryland Middletown 1 □Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4187 Palomino Lane 21769 United States items 23a Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 2 X No Baltimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 2 No Specify: þ White Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 5+ College (1-4or 5+) than, Elementary/Secondary (0-12) Health and Mental Hygiene. Owner/Operator Real Estate 17. Father's Name (First, Middle, Last) æ 18. Mother's Name (First, Middle, Maiden Surname) - Iril Wells Iris Belle Wells ဂ္ Willard P. Campbell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health a Important: If item 27 is any Injury or other trau once. Kenneth M.W. Fox / Husband 4187 Palomino Lane, Middletown, MD 21769 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/22/2008 Olivet Cemetery Frederick, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home our their 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** /Medical Examiner Sequentially list conditions, if any histories in the discause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed Exami burlal-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical the as IF FEMALE for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetai death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 □ Yes 2 No Month Day Year 5 ☐ Other (specify) ed by the detached f signed I Part il. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been significate bases in page 2 should b Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? 1 ☐ Yes 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) al or Attending P safter death. I Director: After t d in by the funera 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only one) and manner stated 29b. Signatu And title of certifier 29d. Date signed (Month. Dav. Year) MDD67210 12//19/2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kniksaj MP NOMIS 400 West 7th St., Frederick, MD 21701 31. Date filed (Month, Day, Year) State 32. Registrar's Signature Bloque B. Sparle Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amend Items23aPtI,25,27,28a-f per me 9887,01/23/09dhb
Reg. No. 2 For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Vear **Physician** 2008 25 1 15 Hazel Irene Ford December /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Frederick Frederick Memorial Hospital Frederick 6. Sex If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Min. 1 □ M 2 🖾 F Months Days Hours 82 3,1926 Director 390-209075 Wisconsin Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a State 10h County 28a-f show d other than "natural", or items 23a or 28a-f shorevent, the Medical Examiner must be nothed at 1 ☐ Yes 2 No Director Maryland Frederick Adamstown 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 3200 Baker Cr./ Unite I-216 21710 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐Yes 2 🛛 No Specify Specify: White ð 3 ₩ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Administration County Schools 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Oscar Norman Jensen Stella Gifford Mav 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important; If item 27 Is r any Injury or other traum once. Mark W. Ford / Son 1402 Rectory Lane / Upper Marlboro, MD 20772 20b. Place of Disposition (Name of cemetery, crematory or other place)
MD. Veterans 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 01/07/2009 | Cheltenham, Maryland 22. Name and Address of Facility Stauffer Funeral Home 21. Signature of Funeral Service Licensee 1621 Opossumtown Pike/ Frederick, MD 21702 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate use (Final disease or condition resulting in death) Supdural **Physician** DAYS /Medical Due to (or as a consequence of) Examiner OVID BYMEDICAL EXAMINER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transi and CERTIFICAT Due to (or as a consequence of): attending physician for use as the buria law requires that the death certificate be Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 1 Live birth 2 Fetal death 3 Ectopic pregnancy Day Year 5 Other (specify) signed by the a O 9 Unknown 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ Diabetes 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been signal page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform After this certificate 2 □No 1 □ Yes 2 12 No after death.

Director: After this certific 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 24 hours after death. 1 Natural 2 Accident 5 Pending investigation 12/21/2008 8:00 p.M 1 ☐ Yes 2 XNo Subject fell. 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Bural Route Number, City or Town, State) 3200 Baker Circle, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Home Unit 1-216,Adamstown,MD 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated To the I within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier December 25, 2008 Hospitalist MDD 62180

Registrar

State

30. Name and address

Fauzi

Rizvi

7th Street, Frederich

rson who completed cause of death (Item 23a) (Type, Print)

400 West

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For Amend#19B, 20C Per Fatate of Maryland / Department of Health and Mental Hygiene State Registrar AACO HEALTH DEPT. 12/29/08 CMH Certificate of Death Reg. No. Reg. No. 2008 1. Decedent's Name (First, Middle, Last) 2. Date of Death r 22 2008 **Physician** December Donald Gross 0715 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Lothian
Under 1 Year | If Under 24 Hrs. 61 Ark Rd. <u>Anne</u> Arunde1 Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, June 7 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Year, Months Days Hours 1'**∑** M 2□ F 213-32-8426 73 June 1935 Maryland Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 ☐ Yes 2 😾 No Director Maryland Anne Arundel Lothian 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 61 Ark Rd. 20711 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: Black 2 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Anne Arundel Co. Elementary/Secondary (0-12) College (1-4or 5+) 12th Building Supervisor Board of Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Abraham Gross Vashti Thomas 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2700 Ladygrove Rd. Donald Gross Jr(Son) Mitchellville, Md. 20721 20c, Location - City or Town, State Date 20a. Method of Disposition 20b) Milece of Disposition (Name M cemetery crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Church Cemetery 12-29-08 Crownsville, Md. 4 ☐ Donation 5 ☐ Other (Specify) Manusme Reverse of SeciliSons Mortuary, P.A. 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 821 West St. Annapolis, Md. 21401 Cerebral Vascular accident Immediate Cause (Final disease or condition resulting in death) hours Due to (or as a consequence of): atrial Fibrillation 3 years Sequentially list conditions, if any, leading to initiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Mary 1 Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: Other: 4 Nursing Home 5 M Residence 6 Other (Specify) 1⊠ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

**Physician** /Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryian Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Madical Examiner must be notified at once.

Maryland 21215-0036

altimore,

Division of Vital Records, P.O. Box 68760,

attending physician and for use as the burial-trar cate has been signed by the page 2 should be detached funeral director, Certification: To after death.

i Director: After din by the fur

28a. Date of Injury (Month, Day, Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

State

filled in within 24 hours a To the Funeral D completely filled i

Medical

29a. Certifier (Check only one)

29b. Signature and title of certifier

( )in ban 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Wayne Bicrbaum 134 Owens Ucl4

and manner stated.

Road, West Piver Martino

1 Acertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

038563

29d. Date signed (Month, Day, Year) Docember 22, 2008

31. Date filed (Month, Day, Year) DEC 2 9 2008

32. Registrar's Signature parke

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 25, 2<u>0</u>08 **Physician** December 5:50 A M Richard William Gray /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Laurel 6200 Forest Mill Lane 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Sept 2I, 5. Social Security Number 6. Sex 1 2 M 2 □ F 7. Age (In vrs. last birthday) **Funeral** 1941 Indiana Months Days Hours Sept 311-40-2325 67 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Intern 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State "natural", or items 23a or 28a-f show dical Eveninet must be notified at 1 ☐ Yes 2 ☐ No Director Prince George's MD Laurel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20707 6200 Forest Mill Lane Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status 1 Never Married 2 Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: þ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Printer Printing Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dorothy Louise Bannister Lewis Alexander Gray ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6200 Forest Mill Lane Laurel, MD 20707 Janice V. Gray/wife permit. Pages 1 and 2 Department of Health Important: If item 27 any injury or other tra once. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State W. Arundel Crematory 12/27/08 Odenton, MD 4 ☐ Donation 5 ☐ Other (Specify) Going Home Cremation Service P.O. Box 784 21. Signature of Funeral Service Licenses MO1251 Beverly L. Heckrotte, P. A. Clarksville, MD 21029 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician CHRONIC OBSTRUCTIVE PULTINIMY DISEASE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been director. burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical the 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Vear in the past 12 months? 5 Other (specify) □Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 4 🗹 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 🗓 No 2 🗆 No 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 N Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal (Check only one)

29b. Signature and title of certifier

32

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOHNS

32. Phylistras's Signature

Registrar

HOPKINS OBENTON HD 21113

29c. License number

36063

29d. Date signed (Month, Day, Year)

December 26, 2008

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** December 21 2008 2:25 p Verda Dorethea Gaugh /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Dorchester Cambridge Mallard Bay Care Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days Hours Yrs Sept. 1, 217-30-3191 76 1932 Virginia Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1X Yes 2 No MD Dorchester Cambridge Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 406 Maryland Avenue 21613 USA Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 🗽 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 🔀 No Specify. white þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) deli worker grocery store 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ezra Cochran Grace Dean ျ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 406 Maryland Ave., Cambridge, MD Earl Gaugh husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Park Wood Cemetery 12/23/08 Baltimore, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Thomas Funeral Home P.A. 700 Locust St., Cambridge, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final eous disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9∏Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of performed Steogathat + Action 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **V**No 2 ER/Outpatient 3 DOA Certification: To 1 ☐ Yes 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred

for use as the burial-transi and attending physician s been signed by the should be detached After this certificate has or Attending Physician: director, funeral within 24 hours after death To the Funeral Director: the f

The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

**Funeral** 

Director

items 23a or 28a-f show iner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Examiner once.

**Physician** 

/Medical

Examiner

Baltimore, Maryland 21215-0036

1 Natural 2 Accident 3 Suicide 4 Homicide

5 Pending investigation 6 Could not be determined

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier 6 29c. License number

29d. Date signed (Month, Day, Year) 08

completed cause of death (Item 23a) (Type, Print) and a dress of person 30. Name D. D. NARR 100

and manner stated.

100 Bramble Street Cambridge,

State Registrar

filled in by

DEC Year) 31. Date filed (Month, 2008 2



		ı	For State Registrar	(First, <b>M</b> iddle, La		arylan		artment o	of Health and of Death		ygiene Reg. No	2008	43333
Adv.	Physicia /Medic Examin	al	GEOR  4a. Facility Name (If  Anne Arur	he Finatitution, givended Medical	WILL (restreet and number)	r		Annap	n, or Location of De	Month /2	4c.	County of Death	1741 M
	Funeral Director		5. Social Security Nu 578–34–96 Usual Residence of	510	7. Ag	78 (In yrs. I	last birthday) Yrs.	Months D		Feb. 2.	irth Day, Year) 2, 19	9. Birth Cou Wash	place (State or Foreign intry) Lngton, D.C.
	e Maryland Ba-f show	ctor	10a. State MD	10b. County Anne Art	ındel		y, Town or Lo						10d. Inside City Limits 1
	h with th	al Dire	10e. Street and Num 3312 Mour	nt Airy (	Court			10f. Zip Co 210			10g. Cit	izen of What Cou A •	ntry?
2-003p	be filed within 72 hours after death with the Maryland at Hygiene.  Id hygiene.  Id other than "natural", or items 23a or 28a-f show event, the Marieal Evarinar must be notified at	by Funeral Director	11. Marital Status 1 ☐ Never Marrie 3 🛣 Widowed		12. Was Decedent Armed Forces? 1 □ Yes 2 ☑ If Yes, Give Year or Dates:			Was Deceden If Yes, specify 1 ☐ Yes 2X	of Hispanic Origin? Cuban, Mexican, Pu No <i>Specify:</i>	(Specify Yes or N erto Rican, etc.)	0-	14. Race - Amer Black, White, Specify: Whit	etc.
N-6121	within 72 ho iene. than "natur	Completed	(Speci	15. Decedent's E ify only highest grandary (0-12)	ducation ade completed) College (1-4or s	5+)	(Give life.	edent's Usual C e kind of work of DO NOT use r	ccupation one during most of v etired)	vorking		nd of Business/Ir hinist	ndustry
_	0 = 0 5	To Be Co	17. Father's Name (A	First, Middle, Last	iner		001103		18. Mother's N	Name (First, Middle Dulin Sh			
Mar	ind 2 sho alth and 1 27 is ma er traume	·	19a. Informant's Na Donna Gar						reet and Number or Airy Cour				
Baitimore,	permit. Pages 1 and 2 should be Department of Health and Menti Important: If Item 27 is marked any injury or other traumatic e once.		4X Donation	☐ Cremation 3 ☐ 5 ☐ Other (Speci		GeO Med	rgetov ical (	osition (Name of matory or othe Vn Univ Center	1	c. <sup>Date</sup> 0	Was	cation - City or T hington,	D.C.
Da	permii Depar Impor any in		21. Signature of Fu	neral Service Lice	Serl	_			ddress of Facility Co apolis Roa				vices,P.A.
	Physician /Medical Examiner		23a. Part 1. Enter th shock, or hear Immediate Cause (I disease or conditior resulting in death)	Final	plications that cause one cause on each i a. Due to (or as	5	toge	ter the mode o	dying, such as card	diac or respiratory	arrest,		Approximate Interval Between Onset and Death
,0079	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the aftending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	lical Examiner	Sequentially list con if any, leading to imr cause. Enter Under Cause (Disease or i that initiated events resulting in death) L	ditions, nediate fying njury ast	b. Due to (or as								
O. BOX 0	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent in the past 12 r 1 □ Yes 2 □ 9 □ Unknown	months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal	death 3	☐ Ectopic preg ☐ Other (speci				23d. Date of deliv	very Day Year
cords, P.	equires that en signed b	ģ	Part II. Other signifi	cant conditions	contributing to death b	ut not resu	ilting in the u	inderlying caus	e given in Part I.		/		he cause of death?
ıtaı necc	i; The law re icate has be ; page 2 sho	Completed								24a. Was auto perf 1 □ Yes		24b. Were auto prior to co death? 1 ∐ Yes	opsy findings available ompletion of cause of
7	nysiciar iis certif director	o Be	25. Was case referrence examiner? 1 ☐ Yes 2 ☐	,	Hospital: Inpatie	ent 2	ER/Outpatie	nt 3 🗆 DOA	Other	Death (Check only) g Home 5 \( \bigcap \) Res		3 □Other (Speci	(fv)
SIOU OIS	ding Ph h. After th funeral	tion: T	27. Manner of Death 1 Natural	5 Pending	28a. Date of Inju (Month, Da	ıry	28b. Time of Injury		Injury at Work?	28d. Describe			
DIVISI	tal or Attending rs after death. al Director: After ed in by the fune	Certification:	Accident     S □ Suicide     Homicide	investigatio 6	e Ogo Plana of Ini	ury - At ho c. <i>(Specif</i> y	me, farm, sti		1 ☐ Yes 2 ☐ No ice	28f. Location City or To	(Street an wn, State	d Number or Run )	al Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical	29a. Certifier (Check only one)	1 Certifying P 2 Medical Exa	nysician: To the best miner: On the basis of analymanner st	of examinat	wledge, deat tion and/or in	th occurred at the occurred at	he time, date and pla my opinion, death o	ace, and due to the	e cause(s , date and	and manner as	stated. o the cause(s)
)	To the comp	Me	29b. Signature and t	title of certifier	Hout	y un		29c. Li	cense number	38		signed (Month,	
2	Cot		30. Name and addre	ess of person who	completed cause of c	leath (Item	25a) (Type,	Print) FYEN	E High	tway A	NNA	an Mo	hull, 2008 4401
	Sta Registr		31. Date filed (Monti	DEC 23	2008 32. Registr	ar's Signat	ure A	backer	•				

		-	For State Registrar	State of Maryla		rtment of H			ene 2008	43334
			Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		NANCY L	OUTSE	6-6	*4		December		1400 PM
}	Examin		4a. Facility Name (If not institution, give		noine	4b. City, Town, or	Location of Death		4c. County of Deat	4.7
	Funeral Director		5. Social Security Number 6. Sec 218–64–9935		5. last birthday) _	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.			hplace (State or Foreign untry) yland
	p ,		Usual Residence of Decedent  10a. State 10b. County	100.0	ity. Town or Loc	ation				10d. Inside City Limits
	ehov ehov	5			ccident	2001				1√2 Yes 2 □ No
	28e-1	Director	MD Garrett  10e. Street and Number	, , , ,	ccraent	10f. Zip Code		100	g. Citizen of What Co	untry?
	with with	<u>a</u>	101 Town View Dr.	, Apt. 6		2152	0		USA	,
	me 2;	era	11, Marital Status	12. Was Decedent Ever in	U.S. 13. W	as Decedent of Hi	ispanic Origin? (S	pecify Yes or No-	14. Race - Ame	
36	permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Maryland Department of Heath and Mental Hygiene. Important: if Item 27 is marked other then "natural", or Iteme 23a or 28e-f show important: if Item 27 is marked other then "natural", or Iteme 23a or 28e-f show simportant: if Item 27 is marked other the marked of the Madical Examinat must be notified at any injury or other treumatic event, the Madical Examinat must be notified at ances.	by Funeral	1 <b>X</b> Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Year or Dates:		Yes, specify Cuba ☐ Yes 2 <b>⊠</b> No	Specify:	o Hican, etc.)	Black, White	White
21215-0036	2 hou	Completed	15. Decedent's Edu			ent's Usual Occupa			6b. Kind of Business/	
215	thin 7	nple	(Specify only highest grad	College (1-4or 5+)	life. D	O NOT use retired	i)	Killy		
2	ygien ygien t,	Col	12		Homem	aker	40.44.45.4.41-		Own Home	
Maryland	Mal H	Be	17. Father's Name (First, Middle, Last)					ne (First, Middle, M.		
2	d Mer d Mer mark matic	ţ.	John William Gay  19a. Informant's Name/Relationship (T)	ne Print)	10h Mailine	Address /Street		izabeth C	City or Town, State, 2	Zin Code)
Ma	d 2 sl th and th and 17 is r		Joseph D. Gay/Bro			Box 111,				
ē,	Heal Heal tem 2		20a. Method of Disposition		Place of Dispos	The same of the sa	-		Oc. Location - City or	Town, State
o E	ages ent of ht: If I		1 X Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		ayard Ce			2, 2009 E	Bayard, WV	
Baltimore,	mit. Paartm portar / Injui	1	21. Signature of Fundal Service Licens						ral Homes	
ñ	Depa Impo eny tr		Nazur &	umaw		O. Box 3			21550	
			23a. Part1. Enter the disease, or composhock, or heart failure. List only o	ications that caused the deane cause on each line.	ath. Do not ente	r the mode of dyin	g, such as cardia	or respiratory arres	st,	Approximate Interval Between
all some	Physician		Immediate Cause (Final disease or condition					melas		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conse						0
	Lammer	<u>.</u>	Sequentially list conditions if any, leading to immediate	Due to (or as a conse	aquence of);					
	ted nsit	niner	cause. Enter Underlying Cause (Disease or injury	200 10 (01 43 4 501150	14401100 017.					
	be executed icien and burial-transit	Exami	that initiated events resulting in death) Last	Due to (or as a conse	equence of):					
8760,	cate be executed physicien and the burial-transit	cal		1						
9	death certificate e attending phys ed for use as the	edical								
Вох	eath certific attending p	N/UE	23b. was decedent pregnant	23c. If yes, outcome of preg		Ectopic pregnancy	,		23d. Date of de	
О. В	e deal	Physician/M	in the past 12 months? 1 □ Yes 22 No 9 □ Unknown	4☐Pregnant at time of 9☐ Unknown		Other (specify)			Month	Day Year
<u>P</u>	that the de led by the a detached	P.	Part II. Other significant conditions co	atchuting to death but not re	sculting in the un	darhina cauca au	on in Part I	23e Did toba	acco use contribute to	the cause of death?
Division of Vital Records,	law requires that as been signe	d by	Faith, Other significant conductions co	This start of the	ssorting art the dir	deliying oddae giv	on any art i.	1 🗆 Yes		obably 4 Unknown
CO	aw rec as bee 2 shor	Completed						24a. Was an		utopsy findings available
æ	o - e	E						autopsy perform 1 Yes 2	ed?   death?	completion of cause of
ita	nysicien: Th nis certificete director, pag	Be	25. Was case referred to medical examiner?				26. Place of De	ath (Check only one		
× ×	Physicien: this certific ral director,	မ	1 ☐ Yes 2 ☐ NO	Anich aleman	☐ ER/Outpatient		4   Nulsing I		nce 6 Other (Spe	cify)
n		on:	27. Manner of Death 1	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor		28d. Describe how	v injury occurred	
isio	att :: 0	cat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At	home farm stre		Yes 2 □No	28f. Location (Str.	eet and Number or Ri	ural Route Number
≥	lospital or Attu hours after de cunerel Directo siy filled in by ti	Certification:	4 Homicide determined	building, etc. (Spec	city)	et, ractory, office		City or Town,		
	To the Hospital or Atte within 24 hours after de To the Funerel Directo completely filled in by the	edical	29a. Certifier 1 Z Certifying Phy (Check only one) 2 Medical Exam	sician: To the best of my k ner: On the basis of exami and manner stated.	nowledge, death nation and/or inv	occurred at the tir estigation, in my o	ne, date and place pinion, death occ	e, and due to the caurred at the time, da	use(s) and manner as te and place, and due	s stated. e to the cause(s)
	vithir To th comp	Me	29b. Signature and title of certifier	2.2		29c. Licens			d. Date signed (Mont	, '
			Paul Danil	mille De	2	Hâ	46154		12/30/	2008
		3	30. Name and address of person who c	ompleted cause of death (It	em 23a) (Type, I	Print) / A	nec 1	v Och	10 xx 1 0	10 S1730
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature	oll / re	VETO	Cak	-14 VICA 1	.,,,,
	Regist		JAN - 6 20		A. So	while				

DHMH 17 Rev 1/2001

Certificate of Death

43335

Reg. No.

For State Registrar

	Physicia	an a	1. Decedent's Name (First, Middle, Las	st)		د ۱	LIA	M		Date of Death Month	D - 14	3. Time of Death
	/Medic		OFOKOF	0172	5	-			D	ECEM	BER 24	2008 10 AM
	Examin	er	4a. Facility Name (If not institution, give	street and number)	40me	1	b. City, Town, or		f Death		4c. County of D	Death
			PLEASANT VI CU 1 0 0 0 Nation 5. Social Security Number 6. S	nal Pike			MOUNT	If Under 2			CARR	011
	Funeral		1	DIM 2 F	In yrs. last birti		f Under 1 Year Months Days	Hours	Min.	Date of Birth (Month, Day,	Year) 9.	Birthplace (State or Foreign Country)
	Director		577-26-4633 Usual Residence of Decedent	3	38				Ma	arch 24	4,1920	Maryland
	land ow It		10a. State 10b. County	1	0c. City, Town	or Locat	ion					10d. Inside City Limits
	Mary f sh	Ö	Maryland Freder:	iok	New Mar	·kot						1 □Yes 2Ñ No
	the 28a	rec	Maryland Freder:  10e. Street and Number	ICK I	New Mai		10f. Zip Code			10	Og. Citizen of Wha	t Country?
	3a or	Funeral Director	11521 Crickenberge	er Road			217	7/1			United S	States
	ms 2	Jera	11. Marital Status	12. Was Decedent Eve	er in U.S.	13. Wa	s Decedent of Hi		gin? (Specif	y Yes or No-	14. Race - A	American Indian,
0	after or ite	Ē	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give					, Puerto Ric	an, etc.)		Vhite, etc.
3	ral", c	l by	3 ☑ Widowed 4 ☐ Divorced	Year or Dates:			Yes 2⊠ No	Specify:			Specify:	White
ה ה	filed within 72 hours after death with the Maryland Hygiene. kther than "natural", or items 23a or 28a-f show kther than Wedical Examiner must be notified at	Completed	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	16a.	Deceden (Give kin	t's Usual Occupa d of work done of NOT use retired	ation during most	of working		16b. Kind of Busine	ess/Industry
V	nthin ne. han " e Me	ď	Elementary/Secondary (0-12)	College (1-4or 5+)							o 1 1	
7	led w tygie her ti	ပိ	7	1	L	eliv	very Dri		do Blassa /F		Suburban	Propane
2	be fi	Be	17. Father's Name (First, Middle, Last,	,							Maiden Surname)	
ž	2 should and Men is marke aumatic	Ţ	Ira Gilliam	Total Date ()	101	B. B. 1920			ret S			
	d 2 sh h and 7 is n traun		19a. Informant's Name/Relationship (								City or Town, Sta	, , ,,
ָר ע	s 1 and 2 should be filed within 72 hours after death with the Marylar if Health and Mental Hyglene. Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		Mary Connelly/ Day 20a, Method of Disposition		20b. Place of			berge	r Koa		Market, P 20c. Location - City	Maryland 2177
5	Pages nent of h ant: if ite		1 Burial 2 □ Cremation 3 □	Removal from State	cemeter	y, cremat	torý or other plac	i				
Daltillo	it. Partme		4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lice)		Parkla		Memorial					e, Maryland
ם ם	permit. Pages 1 an Department of Heal Important: If Item 2 any Injury or other once.		India Service Lice	MALLA		Sta	ame and Addres	unera	1 Hom	es P.	A.	1 1 01700
			23a. Part1. Enter the disease, or com	plications that caused th	e death. Do n							Approximate Approximate
			23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final						ourdide or n	sopratory arre	551,	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a MyocA	RDIML	PN	PARCITI	i N				one day
4	Examiner			a. MycAn Due to (or as a co	consequence of	ot):	Bare					<b>-</b>
		Ē.	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a c			y vices	N/K	<u> </u>			Jean
	uted insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury									
,	exection and and all-tra	Exa	that initiated events resulting in death) Last	C Due to (or as a c	consequence o	of):						
00/00	e be sicia e bur			Ld								
0	leath certificate be executed attending physician and for use as the burial-transit	cian/Medical										
Š	n cert	N/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		م الله					23d. Date of	f delivery
0			in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 2   4□Pregnant at tin		5 □ O	ther (specify)	<u> </u>			Month	Day Year
5	at the by th tache	Physi	9 ☐ Unknown	9□Unknown								
'n	ss the gned	by F	Part II. Other significant conditions	_	not resulting in	the unde	erlying cause give	en in Part I.		23e. Did tob	acco use contribu	te to the cause of death?
SDICS	en sie		A 12 herneis	directe						1 □ Ye	es 212 No 3	Probably 4 □Unknown
5	law n as be 2 sh	Completed	Oskoutha?	ys. "						24a. Was ar		e autopsy findings available
Ċ	The ate has bage	mo;								autops perform 1⊟ Yes 2	ned) deat	r to completion of cause of th? Yes 2 no
N La	lan: rtifica stor, l	Be C	25. Was case referred to medical examiner?					26. Place	of Death (C	Check only on		
	hysic nis ce I direc	ToE	1 Yes 2 No	Hospital: 1 ☐ Inpatient	2 ER/Out	tpatient	3□ DOA Oth	er: 4 🗹 Nu	rsing Home	5 Reside	ence 6 Other (	Specify)
5	ng P) fter th		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Y		ime of	28c. Injur Worl				w injury occurred	
2	endi eath. or: A	atic	2 ☐ Accident investigation				M 1 🗆	Yes 2 □ I	No			
	or Att ter de irect irect	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		- At home, far (Specify)	m, street	t, factory, office		28f	Location (St. City or Town	reet and Number on, State)	r Rural Route Number,
ב	ital carries af											
	Hosp 4 hou Fune tely fi	edical	(Check only 2 Medical Exam	nysician: To the best of miner: On the basis of ex	xamination and	, death o d/or inves	ccurred at the tir stigation, in my o	me, date an pinion, dea	d place, and th occurred	d due to the ca at the time, d	ause(s) and manne ate and place, and	er as stated. due to the cause(s)
	To the Hospital or Attending Physician: The law requires that the d within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached	Med	one)	and manner state	d.		29c. Licens					
	T W D		29b. Signature and title of certifier	2000				3c4	69		9d. Date signed (N	24, 2008
ĵ	To		7 7 7 020 4					`				Τ,
	(7)		30. Name and address of person who	completed cause of deal								
	Sta	te	_ /	32. Registrar's		308		unbri		10 21	147	
	Registr		31. Date filed (Month, Day, Year)	2008	· M	Dos	MAL					

			1 - For State Registrar	State of M	aryland / D	epartme Certifica	nt of H	lealth and	d Mental Hy	/giene Reg. No. 2	008	43:	336
	Physici	an	1. Decedent's Name (First, Mid						Date of De Month		Year	3. Time of E	Death
-	/Medic		Albert	Glascoe					12		2008	2100	М
	Examin	er	4a. Facility Name (If not instituti			4b. City		Location of D			ty of Death		
	Funaval		5. Social Security Number		ge (In yrs. last birt	hdav) If Unde	Pri:	nce Fre	derick Hrs. 8. Date of Bi	rth (	Calver	t lace (State or	Foreign
	Funeral Director		216-76-8763	<b>Ж</b> ЖМ 2□ F	1.0	Yrs. Months			din. Anth P	3/1959	MI	try)	roreign
	pc ,		Usual Residence of Decedent		T								
	arylai shov	<u>_</u>	MD Anne	Arundel	10c. City, Town		_				10	od. Inside City 1 ☐ Yes	
	the M	ect	10e. Street and Number	Arunder	r r	iendshi	p Code			40- 00			36 X 140
	with with	Funeral Director	454 Wilson Ct	_		101. 21	2075	Ω		10g. Citizen of			
	death ms 23	era	11. Marital Status	12. Was Decedent	Ever in U.S.	13. Was Dece			? (Specify Yes or Nuerto Rican, etc.)	o- 14. Ra	US ace - Americ		
9	or ite	Ē	1 ☐ Never Married ※※ Ma	Armed Forces	No				uerto Rican, etc.)		ack, White, e	tc.	
21215-0036	72 hours after death with the Maryland natural", or items 23a or 28a-f show Jical Exandrer must be redified at	d by	3 ☐ Widowed 4 ☐ Divorce	of Yes, Give Year or Dates:		1 □Yes	AIAI IVO	Specify:		Spec	fy: Wf1	ite	
7	"natu	Completed	15. Decede (Specify only high	ent's Education lest grade completed)	16a.	Decedent's Usi (Give kind of w	ork done o	luring most of	working	16b. Kind of I	3usiness/Ind	ustry	
12	withir ene. <b>than</b>	뻝	Elementary/Secondary (0-12)	College (1-4or	5+)	`life. DO NOT u		,		Local	602		
	filed Hygi other ent, I	Be C	17. Father's Name (First, Middle	e, Last)		- D OCAII	11000		Name (First, Middle				
lan	should be filed within and Mental Hygiene.  s marked other than " umatic event, it is the	To B	Robert Glasco	oe .				Phv11	is Taylor	r			
Maryland	shot and N s ma	-	19a. Informant's Name/Relation	nship (Type. Print)	19b.	Mailing Addres	s (Street a		r Rural Route Numl		າ, State, Zip	Code)	
Σ,	and 2 ealth n 27 I		Nancy Ann Gla	scoe Spous	e 45	4 Wilso	n Ct.	. Frie	ndship, l	MD 20758	3		
Baltimore,	Pages 1 nent of H int: If iter iry or oth		20a. Method of Disposition	3 Removal from State	20b. Place of cemeter	Disposition (Na y, crematory or	me of other place		Date	20c. Location	•		
Ē	t, Pag tmen tant: tant:		X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other		Lakemo	nt Ceme	•		2/19/2008				
Bal	permit, Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.  Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it a New Jical Examined in profiled at once.		21. Signature of Funeral Service	e Licensot					lardesty l Annapol:			P.A.	
П			23a. Part 1. Enter the sease, shock, or heart failure. Lis	or complications that cause st only one cause on each I	d the death. Do n ine.	ot enter the mo	de of dyin	g, such as car	diac or respiratory	arrest,		Approximate Interval Between	een
	Physician		Immediate Cause (Final disease or condition	-a. Myoc	ARDIA	4 11	VFI	PRLI	1, m			Onset and De	aath
4	/Medical Examiner		resulting in death)		a consequence o								
		-e	Sequentially list conditions,	b. Duni for for as	а приведиению с	n.					_		
	uted	Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events	<		-7							
ó	an an rial-tra	Exa	resulting in death) Last	C Due to (or as	a consequence o	rf):							
8760,	cate be executed physician and the burial-transit	ical		d									
9	ertifica ling ph e as th	Med	IF FEMALE:										
Box	eath certific attending p for use as f	Physician/Med	23b. Was decedent pregnant in the past 12 months?		2 Fetal death			/			ate of delive	,	ear
o.	he de 7 the s	ysic	1 □Yes 2 □ No 9 □ Unknown	4 ☐ Pregnant a	at time of death	5 ☐ Other (s	pecify)				Ontin	Day 16	ai
σ.	that the dened by the stached f		Part II. Other significant condi	tions contributing to death t	out not resulting in	the underlying	ause give	en in Part I.	23e. Did	tobacco use cor	ntribute to th	e cause of de	ath?
Records,	puires than n signed lid be det	d by		DERTENS!	72.		-		10	Yes 2 No	3 ☐ Prob	ably 4 ∐ Ur	nknown
S	w requir s been s should	Completed	,						24a. Was	an 24h	Were autor	sy findings av	vailable
æ	The law te has age 2 s	l mo							- auto	psy ormed?/	prior to con death?	pletion of cau	use of
Vital	lan: rtifica stor, p	Be C	25. Was case referred to medic	al	· · · · · · · · · · · · · · · · · · ·			26. Place of I	1 ☐ Yes Death (Check only	2 No	1 □Yes	2 ∐ No	
of V	<b>hysician;</b> The la his certificate ha I director, page 2	70 E	examiner? 1 X Yes 2 □ No	Hospital: 1 ☐ Inpati	ent 2 ☐ ER/Out	patient 3 D	OA Othe		g Home 5 NRes		her (Specifi	·)	
n O	ding Phi h. After thi funeral	.: E	27. Manner of Death  1 ☑ Natural 5 ☐ Pend	28a. Date of Inj		ime of njury	28c. Injury Work	/ at		how injury occu			
sio	tendleath.	cati		tigation		М		res 2□No					
Division	or Attendater death	Certification:	4 ☐ Homicide deter	mined Zoe, Flace Of III	iury - At home, fan tc. <i>(Specify)</i>	m, street, factor	y, office		28f. Location ( City or To	Street and Num wn, State)	ber or Rural	Route Number	er,
_	Hospital		29a. Certifier 1 Certify	ing Physician: To the best	of my knowledge.	death occurred	at the tin	ne date and n	lace, and due to the	cause(s) and n	nanner as si	ated.	
	To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check only 2 Medica one)	al Examiner: On the basis of	of examination and	d/or investigatio	n, in my o	pinion, death o	occurred at the time	, date and place	, and due to	the cause(s)	,
	viti To	2	29b. Signature and title of certifi	er 1 1-f	101	29	c. License	number		29d. Date sign	ed (Month L	Day, Year)	
	Man	7	1/wwey	1 Dung	seed 1	70	,	1103	158	12/1	7/2	008	
	1/10m		30. Name and address of perso	n who completed cause of a	death (Item 23a) (	Type, Print)	61	131.	MARY	5101	= /	RD	
	Sta	te	31. Date filed (Month Day, Yea	Regist	rar's Signature	1	211/	Wy _	510E	1711	20	764	
	Registr		UEC 22	2008 Cerron	D. 19	parke			158 84AOY 500E				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death Date of Death
 Month 1 Decedent's Name (First, Middle, Last) Year **Physician** GHOLSTON 2.35 M 29 9 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner CLINTON PRINCE GEORGES PINEVIEW FUTURE CARE If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1 ☐ M 2**X** F 92 FEB 6, SOUTH CAROLINA 1916 217-09-4758 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 10b. County 1XYes 2□No Director PRINCE GEORGES FORT WASHINGTON MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number "natural", or items 23a or dical Examiner must be r 2707 SHAWN COURT 20744 UNITED STATES Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Baltimore, Maryland 21215-0036 Specify: Specify: BLACK δ 3 Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) COOK FEDERAL GOVERNMENT 7 is marked other traumatic event, ti 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 12 should be fill h and Mental H 7 is marked oth Be HARRISON WILLIAMS ELLA WILLIAMS ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and Department of Health ard Important: If item 27 is "stury or other tr KELLY WRIGHT/NIECE 2707 SHAWN COURT, FORT WASHINGTON, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 Removal from State HERUTAGE MEMORIAL CEMETERY JAN 5, 2009 WALDORF, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) ENDIA C. THANNION JOHNON 22. Name and Address of Facility THORNION FUNITAL EXME PA 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Cardisoulminary **Physician** disease or condition resulting in death) /Medical Due to (or as a nsequence of): Examiner Coronary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine requires that the death certificate be executed Due to (or as a consequence of): attending physician are for use as the burial. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 ☐ Other (specify) 4□Pregnant at time of death 9 ☐ Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an page 2 s certificate 2 No 1∐ Yes 2 1 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No 26. Place of Death (Check only one) Be Other: 42 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P After this 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Certification: (Month, Day Year) 1 🕰 Natural 5 Pending investigation 1 □ Yes 2 □ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Note Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year)

Box 68760. P.0. or Vital Records, Division

State Registrar

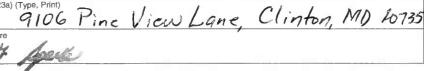
DHMH 17 Rev 1/2001

bahram 31. Date filed (Month, Day, Year) DEC 3 0

29b. Signature and title of certifie

Pishdad. M.D. 32. Registrar's Signature 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



D515-20

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-09548 State of Maryland / Department of Health and Mental Hygiene James Earle Hughes Certificate of Death 1- For State Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day Year December 19, 2008 1526 hrs James Earle Hughes Medical Examiner c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's 12604 Knowledge Lane 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign If Under 24Hrs. 7. Age (In yrs. last birthday) If Under 1 Year 6. Sex 5. Social Security Number **Funeral** Min. Months Days Hours Maryland 08/08/1959 216-76-9362 Director 1X M 2 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 1 X Yes 2 No Prince George's 28a-f show Bowie 10g. Citizen of What Country? Directo 10f. Zip Code 10e. Street and Number USA 20715 12604 Knowledge Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. Funeral 11 Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. must be Armed Forces? Never Married 2 X Married Yes 2 X No Yes 2X No specify: Specify: "natural", o Yes. Give Yea White Widowed Divorced þ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed rre, MD 21215-0036
s 1 and 2 should be filed within 72 hou
f Health and Mental Hygiene
lf item 77 is marked other than "na
ner transmatic event, the Medical Ex College (1-4 or 5+) Elementary/Secondary (0-12) Freight Co. Truck Driver 12 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Doris Watts Earle Hughes Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) Bowie, MD 20715 12604 Knowledge Lane Corinna Slack Hughes / Spouse 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition Baltimore, crematory or other place) Burial 2 X Cremation 3 Removal from State Pages 1 12/24/2008 Baltimore, MD Bayview Crematory Other Specify: Donation 22. Name and Address of Facility Beall Funeral Home rvice Licensee 6512 NW Crain Hwy. Bowie, MD Approximate Interval plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart 23a. Part I. Enter the disease, or **Physician** Between Onset and failure. List only one cause on Death /Medica Gastrointestinal Hemorrhage Immediate Cause (Final disease caminer or condition resulting in death) Due to (or as a consequence of) b. Chronic Alcohol Abuse Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last requires that the death certificate be executed attending physician and or use as the burial - trai Physician/Medical AMENDED UNPENDED O. Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy 3 Ectopic pregnancy Year 23b. Was decedent pregnant in the Fetal death Live birth past 12 months Pregnant at time of death Other (Specify) 5 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by 1 be detache 1 Yes 2 ✔ No 3 Probably 4 Unknown þ Division of Vital Records, P. Completed 24b. Were autopsy findings available 24a, Was an prior to completion of cause of autopsy death? performed? Hospital or Attending Physician: The law 24 hours after death. this certificate has ✓ Yes No Yes 2 26.Place of Death (Check only one) 25. Was case referred to medical Be Other<sub>4</sub> examiner? Residence 6 V Other: Scene Nursing Home 5 DOA ER/Outpatient 3 Inpatient 1 ✔ Yes No 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) After 27. Manner of Death Certification: 1 V Natural Yes 2 No Pending Director: d in by the f Investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be or Town, State) 3 Suicide within 24 hours a To the Funeral I determined (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number

Registra

Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Laron Locke MD. 32. Registrar's Signature 31. Date filed (Month, Day, Year)

29b. Signature and title of certifie

ORIGINAL

O.C.M.E.

December 20, 2008

State

ress of person who completed cause of death (Item 23a)

			1 - For State Registrar	tate of Maryland		rtment of H			giene 008	3 43339
	Physicia	an .	1. Decedent's Name (First, Middle, Last)  Stephen W.	Harris				2. Date of De Month	Day Ye	3. Time of Death
	/Medic Examin		4a. Facility Name (If hot institution, give stree			4b. City, Town, o	Location of De	ath . C	4c. County of E	
	LAGIIIII	C1	Calvert Man	Lordal Hos	spital	Princ	e Free	brick	Cafe	ust.
-7	Funeral		5. Social Security Number 6. Sex 1 M M	7. Age (In yrs. Ia 2□ F 45	est birthday) Yrs.	If Under 1 Year Months Days	Hours M		th ly, Year) 1963 W:	Birthplace (State or Foreign Country) ashington, DC
	Director		Usual Residence of Decedent					11/10/	1703	
	arylan show	2	10a. State 10b. County	10c. City	, Town or Lo	e Freder:	ick			10d. Inside City Limits 1 ☐ Yes 2 📉 No
	the N 28a-f notifie	Director	MD Calvert  10e. Street and Number		TTIME	10f. Zip Code	ICK		10g. Citizen of Wha	t Country?
	h with	ai Di	422 Deane Avenue	9		200	578		U.S	.A.
	r deal	Funeral	Tr. Warker Otalos	Was Decedent Ever in U.S Armed Forces?	S. 13. V	Vas Decedent of H Yes, specify Cuba	ispanic Origin? an, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	14. Race - / Black, V	American Indian, Vhite, etc.
36	irs afte	by F		1 □ Yes 2 ₩ No If Yes, Give X Year or Dates:	1	☐ Yes 21X No	Specify:		Specify:	white
21215-0036	be lied within 72 hours after death with the Maryland Hygiene. Hygiene. All Hygiene. do ther than "natural", or items 23a or 28a-f show event, the Modical Examiner must be notified at	eted	15. Decedent's Education (Specify only highest grade control	on moleted)	(Give	ent's Usuat Occup	during most of v	vorking	16b. Kind of Busin	ess/Industry
7	within nne. than "	Completed	Elementary/Secondary (0-12)	Colfege (1-4or 5+)	life. L	oonoruse retired inkler fi	1)	·	constr	uction
2	filed withi Hygiene. other then	Be Co	12 17. Father's Name (First, Middle, Last)		Spi	IIIRIEI I		lame (First, Middle	. Maiden Surname)	4001011
lan I	should be and Mental is marked of aumatic eve	To B	Theodore F. Ha	arris			Joa	an Mu	rphy	
10			19a. Informant's Name/Relationship (Type,						er, City or Town, Sta rick, MD	
	1 and Health tem 27 other to		Deborah Harris, wif		A	sition (Name of natory or other place		Date	20c. Location - City	
Ē	Pages nent of int: If it iry or o		1 ☐ Burial 2 ☑ Cremation 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify)	oval from State				2/31/2008	Alexand	ria, VA
Baltimore,			21. Signature of Funeral Service Licensee		22	. Name and Addre	ss of Facility	Rausch F	uneral Ho	me, P.A.
10 	Deg m gen year		William R.	J10-					rings, MD	20736 Approximate
			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one call mmediate Cause (Final	ause on each line.	. Do not enti	O O	)	nac or respiratory a	irrest,	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a consequ	ience of):	& fait	ure	- 1		days
	Examiner		Sequentially list conditions. b.	Dehyol	rati	ai &	los	Pailor	e	44,5
	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a Lonsequ	ience of):					
a a	ate be executed nysician and he burial-transit	Exar	that initiated events c. resulting in death) Last	Due to (or as a consequ	ience of):					
	ate be hysicia he bur	cal	d.							
39 xo	that the death certifical ed by the attending phodelached for use as the	Physician/Med	IF FEMALE: 23c	ff yes, outcome of pregnar	ncv				23d. Date of	f dolivon
Bo	death of atten	Iclan	in the past 12 months?	1 Live birth 2 Fetaf 4 Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)	/		Month	Day Year
<u>о</u>	at the by the	hys	9 Unknown	9□ Unknown						
e S	The law requires that the death certifica ste has been signed by the attending ph sage 2 should be detached for use as th	þ	Part II. Other significant conditions contrib	uting to death but not resu	Ilting in the u	nderlying cause giv	ren in Part I.		tobacco use contribu Yes 2□No 3[	te to the cause of death?  Probably 4 Unknown
Records,	w requ	letec	acoust Citt	-6302	<u> </u>		3-56	24a. Was		e autopsy findings available
Re	sician: The law certificate has b irector, page 2 s	Completed						auto perf 1 ☐ Yes	psy prio prmed? dea:	r to completion of cause of
Vital	ertifica octor, p	BeC	25. Was case referred to medical examiner?					Death (Check only		
	Attending Physician: ir death. ector: After this certifics by the funeral director. i	၉	1 Tyes 2 No Hosp 27. Manner of Death 2	ottal: 1 patient 2 :: 28a. Date of Injury	ER/Outpatien	1 3LI DOA			how injury occurred	Specify)
lo	th. :: After s funer	ation	1 Naturaf 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Infury	Wo	rk? Yes 2 □ No			
Division of	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, str	eet, factory, office			(Street and Number own, State)	or Rural Route Number,
Ω	To the Hospital or At within 24 hours after or To the Funeral Directompletely filled in by		29a. Certifier 1 Certifying Physicia	en: To the best of my know	wledge, deatl	occurred at the ti	me date and ol	ace, and due to the	cause(s) and manne	er as stated
	n 24 h n 24 h he Fur	edical		On the basis of examinat and manner stated.						
	To the within 2 To the complete	Σ	29b. Signature and title of certaier	· .		29c. Licens			29d. Date signed (A	/ -
•			30. Name and address of person who comp	lated cause of death //	~1)		06178		(2/29	1/2008
dR	W 5		Chang Choi	100 Hospid	2R R	al, Pru	ce Fra	drick	, MD a	20678
	Sta Regist		31. Date filed (Month, Day, Year) DEC 3 1	32. Registra s Signa	ture #	draits)	P			

Certificate of Death

State of Maryland / Department of Health and Mental Hygiene

43340

Physicia /Medic	
Examin	er

**Funeral Director** 

Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mertal Hygiene.
ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show ant: If Item 27 is marked other than "natural", or other traumatic event, In. Medical Eventual must be nothered.

Baltimore, Maryland 21215-0036 College (1-4or 5+) secretary 17. Father's Name (First, Middle, Last) Be Viola Pear1 ဂ Harvey Smith Walter 19a. Informant's Name/Relationship (Type. Print) William Lineweaver 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department or Important: If any injury or 21. Signature of Funeral Service Licensee William 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** oronary disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner nuterson Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to // as a consequence of) or Attending Physician: The law requires that the death certificate be executed Physician/Medical Exami Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 T Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ZNo 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, <u></u> Completed 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 IDOA 1∐ Yes 2X No Medical Certification: To Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 Homicide 29a. Certifie completely (Check only one) 29c. License number 29b. Signature and title of certifier D16823 30. Name and address of person who completed cause of ceath (Item 23a) (Type, Print) Robert Schlager, M.D. 8924 Chesapeake Avenue, North Beach, MD 20714 32. Registras Signature 31. Date filed (Month, Day, Year) State DEC 3 2008 Registrar DHMH 17 Rev 1/2001 **ORIGINAL** 

1. Decedent's Name (First, Middle, Last) 2. Date of Death December 29 Lavinia R. Harding 2008 6:10 A M 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 702 Charlotte Court Prince Frederick Calvert If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Social Security Number Days Hours Min. 1 □ M 2 🕅 F 04-03-1916 578-12-0921 92 Wash., D.C. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County Completed by Funeral Director 1 ☐ Yes 2 🔯 No Prince Frederick Calvert 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 702 Charlotte Court 20678 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 ☐Yes 2 X No Specify. Specify: 3 ₩ Widowed 4 Divorced white 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 insurance 18. Mother's Name (First, Middle, Maiden Surname, McMichael 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 33 Woodside Road, Chagrin Falls, OH 20c. Location - City or Town, State Ft. Lincoln Cemetery 01-09-2009 Brentwood, MD 22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 20736 Approximate Interval Between Onset and Death 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 12-29-08

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 23 2008 Hoffman Jean Marine December /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Hospita Easton Memorial at taston lalbot If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
April 30,1940 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number **Funeral** Hours Months Davs 1 □ M 2 🛛 F Yrs. 68 Maryland 214-36-5408 April Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10b. County items 23a or 28a-f show ner must be notified at 1 ☐ Yes 2 No No Director Hurlock Maryland | Dorchester 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 4905 Harrison Ferry Road 21643 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status ural", or item: Black, White, etc. 1 ☐ Yes 2 XNo 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🗓 No Baltimore, Maryland 21215-0036 Specify: þ White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) 12 Quality Control Inspector Food Processing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be h and Mental F eq Clara Mills Henson Foxwell Pages 1 and 2 should 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other troone. 6136 Suicide Bridge Road, East New Market, MD 21631 If item 27 Richard Hoffman/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 3 ☐Removal from State 1 XBurial 2 ☐ Cremation 12/27/2008 East New Market, MD East New Market Cem. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Zeller Funeral Home, P. O. Box 207
106 Main Street, East New Market, MD 21631 21. Signature of Fymeral Service Lig 23a. Rank Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one bause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): **Physician** 7 yrs CONCER /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Ursaus or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) attending physician Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown been signed by should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perforn 1 ☐ Yes 2 ☐ No this certificate Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To Manner of eath 28a. Date of Injury (Month, Day 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fi 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

David

31. Date filed (Month, Day, DEC

(.

Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Halveson

STER TO

8821

MD

29c. License number

D66270

29d. Date signed (Month, Day, Year)

Teal DR Suite 302 Easten, MD 21601

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death **Examiner** Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F 62 Director Nov. 20, 1946 Washington, DC 215-46-0626 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show id other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be rediffed at 1 ☐ Yes 2 X No Funeral Director Maryland Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12905 Falling Water Circle 20874 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc filed within 72 hours after 1 ☐Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No ģ Specify. 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 service tech./salesperson heating/air conditioning permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygis Important: If item 27 is marked other any injury or other traumatic event, II 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ျ Edward James Highsmith Margaret Lillian Sullivan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20874 19a. Informant's Name/Relationship (Type. Print) Susan Ann Hennessey Highsmith, 12905 Falling Water Circle, Apt 102, Germantown, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Metropolitan Crematory 12/28/2008 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Molesworth-William Funeral Home 23a. Part 1. Eye The disease, or complications that crus d the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, hart failure. List only one cause on each line.

Immediate Crus (Final disease or confliction resulting in death)

a. Due to (or as a consequence of): 26401 Ridge Road, Damascus, Maryland Approximate Interval Between Onset and Death Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine that the death certificate be executed burial-tran and Due to (or as a consequence of): physician Physician/Medical the attending pl for use as t Box IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 ☐ Other (specify) Ö 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ Records, CHRENK OBSTRUCTIVE PULMONA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed page 2 should DISEASE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No Vital 1 □ Yes 2 🗀 No 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending Division 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A 2 Accident investigation npletely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital Medical 29a. Certifier 1 🗲 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 o the F one) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of

State Registrar

31. Date filed (Month

10605

ANCORD ST #500 KENSINGTON, MD 2089\$

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9

State of Maryland / Department of Health and Mental Hygien ? \( \begin{align\*} \begin{align\*} \text{ Mental Hygien} \\ \begin{align\*} \emptyre{\text{ Mental Hygien}} \\ \emptyre{\text{ Mental 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Dav ay Year 28 2008 Month **Physician** 11:04 PM December Barbara Ann Howard /Medical 4c. County of Death 4a. Facilify Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Memorial Hospital Frederick Frederick If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Hours 1 □ M 2 🕱 F Days Apr. 26, 1954 Virginia Director 219-64-0633 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits show 10a. State 10b. County 27 Is marked other than "natural", or Items 23a or 28a-f shor traumatic event, the Modeal Event, that he notified at 1 ☐ Yes 2 X No Director Jefferson Maryland Frederick 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 21755 2910 Jefferson Pike Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No White Specify Specify: þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within thand Mental Hygiene.
7 Is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) 10 U.S. Government Custodian 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked, any injury or other traumatic evone. Mary Evans Harold Kegley ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Norman M. Howard, Jr. / Husband Jefferson, Maryland 21755 2910 Jefferson Pike 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State January 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 2, 2009 4 ☐ Donation 5 ☐ Other (Specify) Resthaven Mem Gardens Frederick, Maryland 21. Sign were of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Homes, P.A. Frederick, Maryland 21702 1621 Opossumtown Pike Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Due to (or as a consequence of): dark disease or condition resulting in death) /Medical Examiner myo cardial into if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Exami Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ۾ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🔽 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2√No 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Teath 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1× Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier mon MD. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9th Ave Brusswick, MD 21716 CHAN-HING HO 610 MO 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

BEC3 0

				Plea	se Ty	pe or Pi	int in	Black	k Ind	delible	e Ink.	Ens	ure A	I Copies	s Are	Legi	ble.		
			For 1 _ State		5	State of N	Maryla		•					lental Hy	/gien	e			
			Registrar  1. Decedent's Nam	ne (First Middle	a last)				Cert	titicai	e or i	Death		2. Date of D	Reg. N	10. 2	108	3 Time	1344
	Physicia		1. Decedent's Nam			Alban	Hamm	ann						Month Dec.	D	30 2	Year 2008	8.00	) A M
	/Medic Examin		4a. Facility Name (i							4b. City	Town, or	r Location	of Death	2001		c. County			, 21
1	); ;;;		Mornings									ott C	- part			Нс	ward		
	Funeral		5. Social Security N 213 03 5		6. Sex 1 ☐ M	7. 1.2 <b>X</b> ) F	Age (In yı 93	rs. last birt	hday)_ Yrs.	Months Months	Days	If Under Hours	Min.	8. Date of Bi (Month, D Apr 13	av Yea	015	9. Birth Cou	place (State intry)	or Foreign
ŀ	Director		Usual Residence o											Apr 13	), 1.	213	LIL		
	arylan show d at	ī	10a. State	10b. County				City, Town		ation								10d. Inside C	ity Limits
	the Ma 28a-f	Director	MD 10e. Street and Nu	Howa	rd		C	olumb	oia	10f. Zij	Codo				10a C	itizen of V	Mhat Cou		225 110
	3a or	i Dir	5114 No		Fence	es Lane	2				21044	1				nite		*	
	death	Funeral	11. Marital Status			. Was Decede Armed Force	nt Ever in	U.S.	13. W				rigin? (Sp	ecify Yes or N Rican, etc.)		14. Rac		can Indian,	
2	s after ; or ite amine	by Fu	1 ☐ Never Mari 3 ☑ Widowed	_		1 ☐ Yes 25	<b>N</b> o			Yes		Specify				Specify	<i>/</i> ·		
Ś	tural'		2X1 MIGOMEG	15. Deceden		Year or Date	S:	16a.	Decede	ent's Usu	al Occup	ation			16b.	Kind of Bu		ite Idustry	
2	thin 72 e. an "na Medik	Completed	(Spec	cify only highe ondary (0-12)	stgrade c	ompleted) College (1-4	or 5+)	-	(Give k life. D	kind of wo O NOT u	rk done i se retired	during mo: d)	st of work	ing				,	
7	be filed within 72 hours after death with the Maryland Hygiene. At Hygiene. Ad other than "natural" or items 23a or 28a-f show event, the Medical Examiner must be notified at		12		1 1				Н	Iomen	naker T		NI	(F) A &			Home	:	
2	d d d d d d d d d	Be C	17. Father's Name  James C.										ra Sr	e (First, Middle na 11	e, Maide	en Surnan	ne)		
7	12 should be filed within h and Mentai Hygiene. 7 is marked other than 'traumatic event, the Metraumatic event e	To	19a. Informant's N			. Print)		19b.	. Mailing	g Addres:	(Street			al Route Num	ber, City	or Town,	State, Zi	p Code)	
_	and 2 ealth a n 27 is her trai		Frederic	ck B. H	iammar	n III/							ces I	Lane Co	luml	oia,	MD 2	1044	
ט ס	Pages 1 and 2 should nent of Health and Men nrt: If item 27 is marke rry or other traumatic		20a. Method of Dis		3 □Ren	noval from Sta	ite i	Place of cemeter	_					Date				own, State	
	it. Pa rtmen rtant: njury		4 ☐ Donation  21. Signature of Fi	· · · · · · · · · · · · · · · · · · ·				Arder			_			L-2008		nover	•		
ם	permit. Pages 1 and 2. Department of Health a Important; if item 27 is any injury or other trau		Show Show	m (H	lm	-	M01	044	11	12 (	13 0		"Harı	ry H. W Pike El	litzl	ce's	Fami	ly FH	Inc.
	=		23a. Part1. Enter t	the disease, or art failure. List	complica	tions that caus	sed the de	eath. Do n									·ILY	Approxima Interval Be	te
1	Physician		Immediate Cause disease or condition	(Final	a	Myocar		Infa	arct	ion								Onset and minut	Death
	/Medical Examiner		resulting in death)			Due to (or Nonisc			,	was rox	-2+b	,						10 ye	) arc
b	4 4	er	Sequentially list co	onditions, mmediate	b	Due to (or				AUYOL	aury						-	TO ÃE	ars
	cuted nd ransit	Examiner	Cause. Enter Under Cause (Disease or that initiated events	erlying r injury s	<b>S</b> c	Hypert	ensi	on										20 ye	ars
Ś	be executed iician and burial-transit	_	resulting in death)	Last		Due to (or	as a cons	equence o	of):										
0	eath certificate be attending physici for use as the bu	dica			d				-										
<b>X</b>	r certif	n/Me	IF FEMALE: 23b. Was deceder	nt pregnant	23c	. If yes, outcor			۰.	m-41-						23d. Da	te of deliv	rery	
	ed for	sician/Medica	in the past 12 1 ☐ Yes 2	L <b>an</b> o		1 ☐ Live birth 4 ☐ Pregnan 9 ☐ Unknown	t at time o			Other (s						Mo	nth	Day	Year
	hat the	Phy	9 ☐ Unknowr Part II. <b>Other signi</b>		ons contri			esultina in	the und	derlyina	ause giv	en in Part	I.	23e. Did	tobacco	use cont	ribute to	the cause of	death?
ה ס	w requires that the de been signed by the a should be detached	d by									J.							bably 4 🔀	
5	s beer s shou	olete												24a. Wa:		24b.	Were aut	opsy findings	available
	sician: The law s certificate has b lirector, page 2 s	Completed											_		opsy formed? 2 <b>X</b> N		prior to co death? 1 ∐ Yes	ompletion of o 2□ No	ause of
V   [2	tending Physician: The eath.  tor: After this certificate he the funeral director, page	Be	25. Was case refe examiner?	_		spital:					Oth			h (Check only					
5	Phys r this eral dir	: To	1 ☐ Yes 2 2 27. Manner of Dea		11100	28a. Date of I	njury	ER/Out	ime of		28c. Injur Worl	4 ⊔ N	1	me 5 Res				wasstd	. live
5	ath. rr: Afte	atior	1 XNatural 2   Accident	5 Pendir investi		(Month,	Day Year)	) Ir	njury	М		k? Yes 2□	- 1						
2 2	or Atte ter de: irecto irecto	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 🗌 Could determ		28e. Place of building,	injury - At etc. <i>(Sp</i> e	home, far	rm, stre	et, factor	y, office			28f. Location City or To			er or Rui	al Route Nur	nber,
ב	pital control of the		29a. Certifier	1 X Certifyii	na Physic	lan: To the be	est of my k	nowledge	death	occurred	at the tir	me date a	and place	and due to the	a callea	(s) and ma	anner se	stated	
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check only one)	2 Medical	Examine	r: On the basi and manner	s of exam	ination and	d/or inv	estigatio	n, in my c	ppinion, de	eath occur	red at the time	e, date a	nd place,	and due	to the cause(	s)
	To th withir To th comp	Me	29b. Signature and	d title of certifie	r [ ]		_	0	1	111		e number				_		Day, Year)	
,	7.1		Kat	hleer	- Je	rlc-	Jon	dan	1		D370	11			12	2/30/	2008		
	100		30. Name and add Kathleer								d C:-	iite '	103 =	llicot	+ C+	i <del>1 1</del> 77	MD 2	1043	
7	Sta	ite	31. Date filed (Mor	nth Day Year	1 001	32. Bygi	istrar's Sig	gnature .	144	ye r	u Du	c	TOO I			LCY,	2 س		
	Registr			UEC 3	1 200	JO A	eun	Ø.	19	arks									

Registrar DHMH 17 Rev 1/2001

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

orge William H	1- R	For State	Department of Certificate of		Reg. N	200	8 4334
Physician dical Examine	er	Oecedent's Name (First, Middle,Last)  GEORGE WILLIAM HOLDER		D	Date of Death Month Oa ecember 31	y Year , 2008 4c. County of Deat	3. Time of Death 1933 hrs
	4	a. Facility Name (if not institution, give street and number)     Washington County Hospital	4	b. City, Town, or Location of Oeath · · ·  Hagerstown		Washington	1
Funeral Director	5		(In yrs. last birthday)  60 Yrs.	Mantha Cours Hours Min	Oate of Birth (M	1948 G	rthplace (State or gn puntry) MARYLAND
1 1170 1 7 3 5 10 10	_	Usual Residence of Oecedent  0a. State 10b. County 1	Oc. City, Town or Locati	on			10d. Inside City Limits
ow any			100. Oky, 101111 of 2000	KEEDYSVILLE			1 Yes 2 X No
Marykand 28a-f show d at once.		MARYLAND WASHINGTON  0e. Street and Number		10f. Zip Code	10g.	Citizen of What Cou	intry?
th the Maryland 23a or 28a-f sho		4007 CHESTNUT GROVE ROAD		21756		U.S.	
th with	Funeral	1. Marital Status 12. Was Oecedent E 1 Never Married 2 X Married Armed Forces?	Ever in U.S. 13. Was	s Decedent of Hispanic Origin? (Specifies, specify Cuban, Mexican, Puerto Ric	y Yes or No- an, etc.)	14. Race - Ame White, etc.	rican Indian, Black,
		1 Yes 2	No 1	Yes 2 X No specify:		Specify:	WHITE
ours'af atural xamin	6 0	15. Oecedent's Education (Specify only highest grade comp		t's Usual Occupation (Give kind of work ost of working life. DO NOT use retired)		b. Kind of Business	/Industry
hin 72 h	pleted	Elementary/Secondary (0-12) College (1-4 or 5	+)	SUPERVISOR		RAILRO	MD
8 · F · E · E · E	Comple	12	_, 1	18.Mother's Name (Fi	rst, Middle, Mai		JAD
	Be	RICHARD HENRY HOLDER		MARGARET	IDELL T	HOMPSON_	7.011
→ 점 点 := =   .	유	9a. Informant's Name/Relationship (Type, Print )	4	Address (Street and Number or Rura CHESTNUT GROVE RO			
Sre, MC es I and 2 s of Health an If item 27 her traums	+	VICKIE L. HOLDER/SPOUSE	20b. Place of Dispos	ition (Name of cemetery, D		Oc. Location - City o	
Baltimore, I permit; Pages I and Department of Heal Important: If item injury or other tra-	1	1 X Burial 2 Cremation 3 Removal from Sta		E HGTS. CEM 1/06	/2009 1	BROWNSVIL	LE. MARYLAND
altir mit. P partme portai	-	4 Oonation 5 Other Specify: 21. Signature of Funer Service Ligensee	22. N	lame and Address of Facility BAST-	-STAUFF	ER FUNERA	L HOME
	1	Paul Paul Paul Enter the disease, or complications that caused	M. Dean 76	06 Old National P	ike, Boo	onsboro,	MD 21713 Approximate Interval
Physician Medical		failure. List only one cause on each line.	Cardiovascular Dis		ophatory arroot	onesi, er neer	Between Onset and Death
kaminer		Immediate Cause (Final disease or condition resulting in death)  Afficiacy  Oue to (or as a conse		ease			
		Sequentially list conditions, if any, leading to immediate b. Due to (or as a conse	guence of):				-
	Examiner	Cause, Enter Underlying Cause (Disease or injury that initiated					
ed usit	Exal	events resulting in death) Last  Due to (or as a conse	quence of):				
0, be executed sician and ourial - transit	adical	UNPENDED AMENDED					
		IF FEMALE: 23c. If yes, outcom				23d. Oate of delive	
Box 6876( e death certificate the attending physed for use as the b	Physician/M	23b. Was decedent pregnant in the past 12 months?		etal death 3 Ectopic pregnancy ther (Specify)	у	Month	Oay Year
Box e death the atte	hysi	1 Yes 2 No 9 Unknown g Unknown			Loo. Didash		le the source of donth?
that the d	by P	Part II. Other significant conditions contributing to death	but not resulting in the	underlying cause given in Part I.			to the cause of death?
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the rs after death.  The Third read that this certificate has been signed by led in by the funeral director, page 2 should be detach.					24a. Was an		autopsy findings available
cords, law requir	Completed				autopsy perform	ed? death1	
tal Rec		25. Was case referred to medical		26.Place of Death (Check onl	y one) Yes 2	No 1 🗸	Tes 2 INO
Vital I hysician: this certifi I director,	B B	evaminer?	ent 2 🗸 ER/Outpatien	t 3 DOA Other Nursing I	Home 5 Re	esidence 6 Oth	ner:
n of Jing Ph After t funeral	۲ħ	27. Manner of Death 28a. Date of Inju (Month, Day,Y	ry 28b. Time of ear)	,,	8d. Describe ho	w injury occurred	
IVISION  Or Attendi after death.  Director: d in by the f	gatic	2 Accident Investigation	ium. At homo form otro	1 Yes 2 No eet, factory, office building, etc.	Rf Location (Str	eet and Number or	Rural Route Number, City
Divis	Certification:	Suicide 6 Could not be determined (Specify)	jury - At nome, farm, stre	set, factory, office building, etc.	or Town, Sta		Total House Hamber, Oly
Division of Vital Records, P.O. Box 6876( To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director; page 2 should be detached for use as the b	Medical Ce	29a. Certifier 1 Certifying Physician: To the best of m (one) 2 Medical Examiner: On the basis of example 2	y knowledge, death occu mination and/or investiga	urred at the time, date and place, and duation, in my opinion, death occurred at t	ue to the cause( he time, date an	s) and manner as si d place, and due to	tated. the cause(s)
To witl	Mec	29b. Signature and title of certifier	1	29c. License number		29d. Oate signed (A	
		Calsson St	P. (	O.C.M.E.		January 1, 200	9
1 12		30. Name and address of person who completed cause of c		on Street Baltimore MD 0400	n1	· · · · · · · · · · · · · · · · · · ·	
1-10		Zabiullah Ali, M.D. Assistant Medical Ex	xaminer 111 Pei	nn Street, Baltimore, MD 2120			
St: Regist	ate rar	31. Date filed (Month, Day Year) 5 2009 32. Resistra		ale			
HMH 17 Rev 1/20			ORIGINA			00110	

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 3:14 p <sup>M</sup> 12/4/2008 MELDA HAYNES /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Clinton Nursing Home & Rehab. Clinton Prince George's If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days Hours Min 1 ☐ M 2 🕱 F Yrs 11/20/1919 Ostego, 89 Director 234-40-8356 Usual Residence of Decedent be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State ral", or items 23a or 28a-f show Examiner must be notified at tx∏Yes 2 □ No Director Maryland Prince George"s Forestville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20747 United States 1711 Bradmoore Drive Funeral 14. Race - American Indian, Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: Black þ 3 ☑ Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) other traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Private Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be of Health and Mental Thurlan Meadows Mamie Lee ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 sinent of Health an ant: If Item 27 is r Ora M. Haynes\_/ Daughter 5025 Blaine Street N E Washington, D.C. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ō permit. Page Department o Important: If any Injury or n Cemetery 12/12/2008 Princeton, WV 22. Name and Address of Facility Pope Funeral Homes, F.A. 4 □ Donation 5 □ Other (Specify) Roselawn Cemetery 21. Signal re of Funeral Service Licen je 5538 Marlboro Pike Forestville, maryland 20747 23a. Part f. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) entles Vastale. Discarely those Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a con or q Examiner burial-tran Due to (or as a consequence of): pe Physician/Medical the attending p as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) signed by the a Ö 9 Unknown 9 Unknown ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy , page performe certificate 1 Yes 2 No Division or Vital Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 [] Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After 1 🖾 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the 29a. Certifier (Check only one) Medical In the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title 30. Name and address of person who co 32. Registrar's Signatur 31. Date filed (Month, Day, Year State 2 2009 Registrar

08-09822

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

ilcia Howard		State of Maryland / Department of Health and Mental to Propertificate of Death	Reg. No. 20	08 4334
Physicia	_	Registrar  1. Decedent's Name (First, Middle, Last)	2. Date of Death	3. Time of Death
edical Exami	ner	FELICIA TARA KRISTINA HOWARD	December 29, 2008	1925 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Dea 8016 Ritchie Highway Pasadena	4c. County of De	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24H		
Director			11. 6-4-72 Fo	reign Country)
	- 1	Usual Residence of Decedent		
w any		10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits  1 Yes 2 You
Maryland 28a-f show d at once	호	Mo ANNE ARUNDE PASADEIM  10e. Street and Number  10f. Zip Code	10g. Citizen of What (	
ne Mar or 28s	Director	8012 RITCHIE HWY 21122	0.5	
with the Maryland ous 23a or 28a-f sho be notified at once	ra [	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin?		merican Indian, Black,
death or iter	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Pue	Δ	Ingv
s after ral",	क्र	3 Widowed 4 Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind	Specify: 16b. Kind of Busine	ess/Industry
72 hour	eted	Elementary/Secondary (0-12) College (1-4 or 5+)	retired)	= 1
5-0036 led within 72 hours a Hygiene. other than "natura the Medical Exami	Completed	12 CAREGIVER	HOMEH	EALTA
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Meintal Hygier Meintal Hygier 1 is marked of ther than "natural", or items 23a or 28a-f she matic event, the Medical Examiner must be notified at once			me (First, Middle, Maiden Surname)	
2121 ould be fi Mental I marked	To Be		or Rural Route Number, City or Town, S	State, Zip Code)
e, MD 21215-003 I and 2 should be filed withi Health and Meintal Hygiene. item 27 is marked other th			SODENH, MD 21122	
Tore, ME ages I and 2 s int of Health an it: If item 27		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery), crematory or other place)	Date 20c. Location - Cit	y or Town, State
Baltimore, permit: Pages I at Department of He Important: If ite		4 Denation 5 Other Specify: HUL CRUS CEMETERY 1-	7-09 KADOKKYNY	IRK MD.
Baltimore permit: Pages I Department of F Important: If injury or other			HUGHERTY FUNERAL PASADENA, MD. 2112	
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia	c or respiratory arrest, shock, or heart	Approximate Interval Between Onset and
/Medical		failure. List only one cause on each line.  Immediate Cause (Final disease a Multiple Injuries		Death
A		or condition resulting in death)  Due to (or as a consequence of):		
	Jer.	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):		
./	Examiner	CUISease or injury that initiated events resulting in death) Last Due to (or as a consequence of):		31
Scuted A	Ĕ	dd.		
Box 68760, the death certificate be execut the attending physician and ned for use as the burial - trained for use as the buri	Medical	UNPENDED		
3760 ficate   g phys	/Me	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pre	23d. Date of de egnancy Month	livery Day Year
x 68 th certi ttendin r use a	/sician/	past 12 months?  4 Pregnant at time of death 5 Other (Specify)		1
. Bo he dea y the a	Phys	Yes 2 No 9 Unknown 9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribu	te to the cause of death?
, P.O. B res that the d signed by the be detached	5	Tark in Other Significant contained Contained in the Cont	1 Yes 2 No 3	Probably 4 🗸 Unknown
cords, law require has been si	Completed			re autopsy findings available r to completion of cause of
e law te has l	l du		performed? dea	
Vital Rec ysician: The his certificate director, page	Be Co	25. Was case referred to medical 26.Place of Death (Che		
Vita hysici this ca	일	1 Yes 2 No	ursing Home 5 Residence 6 🗸 0	Other: Scene
n of \ding Phy. h. After tl		27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Subject pedestrian struck i	by motor vehicle
isio Atten	icati	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (Street and Number of	or Rural Route Number, City
Div ital or urs after rral Di	Certification:	Suicide 6 Could not be determined (Specify) Major Road / Highway	or Town, State) 8016 Ritchie Highway, Pasade	na, MD
Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial – transi		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred.	and due to the cause(s) and manner as	stated.
To th within To th	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurr and manner stated.  29b. Signature and title of certifier  29c. License number		(Month, Day, Year)
	-	200. Olgitatoro ano tato oi ociano	OCME December 30	
n.		30. Name and address of person who completed cause of death (Item 23a)		
7		Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltin	nore, MD 21201	
S Regi:	State			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2008 4:05 AM December Anthony F. Jones 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Prince George's 1857 Manorfield Court Mitchellville If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Oct. 11, 9. Birthplace (State or Foreign Country) 1961 Washington, D.C 5. Social Security Number 6. Sex 1 M 2 □ F 7. Age (In vrs. last birthday) 579-80-0257 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 □Yes 2 XNo Prince George's Mitchellville 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 20721 USA 1857 Manorfield Court 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☒No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. ATTICAN 1 □Yes 2 X If Yes, Give Year or Dates: 1 XNever Married 2 Married Specify: American 1 ☐ Yes 2 📉 No 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Radio Advertising Accountant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Marion Frances Coates Roland E. Jones 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1857 Manorfield Ct. Mitchellville, MD 20721 Barbara J. King/sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Odenton, MD W. Arundel Crematory 12/26/08 4 ☐ Donation 5 ☐ Other (Specify) Going Home Cremation Service P.O. Box 784 21. Signature of Funeral Service Licens Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 1/2 years a. Anal Cancer disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 DUnknown

Physician /Medical Examiner

law requires that the death certificate be executed

Box 68760.

P.O.

Division of Vital Records,

**Physician** 

/Medical

Examiner

Director

Funeral

à

Completed

Be

MD

**Funeral** 

**Director** 

ed other than "natural", or items 23a or 28a-f show event, the Medical Exeminar must be notified at

72 hours after

12 should be filed what and Mental Hygier 7 is marked other the

permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked 1 any Injury or other traumatic evo

3altimore, Maryland 21215-0036

Exami

burial-trar physician Physician/Medical the attending p signed by the a 2 icate has been sig Completed director, Be Certification: To this funeral ie Hospital or Attending Pl n 24 hours after death. ie Funeral Director: After t After To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A completely filled in by the fu

IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

6 Could not be determined

23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24a. Was an

autopsy 2 No 1 ☐ Yes 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medica examiner? 1 ☐ Yes 2 🔯 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 5 ☐ Pending investigation 1 X Natural

and manner stated

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature and title of certifier

2 Accident

3 Suicide

29a. Certifier

4 Homicide

29c. License number

29d. Date signed (Month, Day, Year)

D43083

December 24, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

George A. Sotos, M.D. 9707 Medical Center Drive #300 Rockville, MD 20850

State Registrar

Medical

			For State	State of Mai	ryland / Depa	rtment of h		-	201	18 13319
		_	Registrar		Cer	lilicate of	Dealli	2. Date of Death	3	3. Time of Death
н	Physici	an	1. Decedent's Name (First, Middle, Last		T	-		Month	Day Y	ear
	/Medic	al	Janie	Mae	Jame		or Location of Death		26 200 4c. County of	
	Examin	er	4a. Facility Name (If not institution, give Genesis HealthC		e Pines		Caston			lbot
	Funeral		5. Social Security Number 6. Se	X 7. Age	(In yrs. last birthday)	If Under 1 Year Months Days		8. Date of Birth (Month, Day,	Year)	Birthplace (State or Foreign Country)
10	Director		113- 34-4530		82 Yrs.			April 23	1926	Virginia
_	and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
`	/arylised sho	ō	MD. Talb		Eas	FOR				1. Yes 2 No
5	the last	Director	10e, Street and Number	) /	2 0 0	10f. Zip Code		10	g. Citizen of Wh	at Country?
	3a or		18 Lynnbro	ONK CO	urt	2	1601		1151	4
	ms 2	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?	ver in U.S. 13.	Was Decedent of I	Hispanic Origin? (S can, Mexican, Puert	pecify Yes or No-		American Indian, White, etc.
9	after or ite		1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2 No	o	1 □ Yes 2 🕱 No			Specify:	<i>O</i> :
ဗ္ဗ	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show dical Examiner must be notified at	d by	3 Nudowed 4 Divorced	Year or Dates:						Black
5	"natu	Completed	15. Decedent's Edi (Specify only highest grad	ucation de completed)	(Give	dent's Usual Occu kind of work done DO NOT use retire	during most of wor		6b. Kind of Busi	ness/industry
12	filed within Hygiene. other than '	ᇤ	Elementary/Secondary (0-12)	College (1-4or 5+	) Menta	1 Hygie		4Aide	State	Hospital
0	filed with Hygiene. other thar ent, the N	ပိ	17. Father's Name (First, Middle, Last)		7 10 101	779		ne (First, Middle, M	laiden Surname)	
an	should be filed within 72 hours after death with the Marylan and Mental Hygiene. marked other than "natural", or items 23a or 28a-f show marked other than "natural" or items 25a or 28a-f show marke event, the Medical Examiner must be notified at	To Be	Ernest	James			EMA	1a Sh	eppai	rd
Maryland 21215-0036	or a or ⊃		19a. Informant's Name/Relationship (7	vpe. Print)	19b. Mailir	ng Address (Stree	t and Number or Ru	ıral Route Number,	City or Town, St	
	t and 2 Health a tem 27 is	100	Cynthia F	osque	294		hewstor		4 Stun	1, MD.21601
ore	8 6 - 2		20a. Method of Disposition 1 M Burial 2 □ Cremation 3 □	Bemoval from State		natory or other pla				fy or Town, State
Ĕ	Pages ment of h ant: If ite	١.,	4 ☐ Donation 5 ☐ Other (Specify	)	Richards			31/08/	-asta	IN, MD.
Baltimore,	permit. Page Department of Important: If any Injury of once.		21. Signature of Funeral Service Licen	Jenry	27	2. Name and Addr PORY I	Luneral	HOME,	P. A. Cambri	dge, MD. 21613
			23a. Paid . Enter the disease, or comp shock, or heart failure. List only	lications that caused tone cause on each line	death. Do not ent	er the mode of dy	ring, such as cardia	or respiratory arre	est,	Approximate Interval Between
7	Physician		Immediate Cause (Final disease or condition	Aleki	emors des	mentin				Onset and Death
)	/Medical		resulting in death)	Due to (or as a	consequence of):		-			
18	Examiner	_	Sequentially list conditions, if any, leading to immediate	b	consequence of):					
	ed sit	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence or).					
	The law requires that the death certificate be executed the has been signed by the attending physician and mage 2 should be detached for use as the burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or as a	consequence of):					
8760	be e siclan burit		l	d						
687	ficate t physics to the b	edic		u.						
Box	death certific attending pl	N/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome p	of pregnancy	7c-t			23d. Date	-
	death e atte	icia	in the past 12 menths? 1 ☐ Yes 2 No	4□Pregnant at t		∃Ectopic pregnan ∃Other <i>(specify)</i> <sub>-</sub>			Mont	h Day Year
P.0	ires that the de signed by the be detached	Physician/Medical	9 □ Unknown				-			
	es tha gned be de	by F	Part II. Other significant conditions of	ontributing to death bu	t not resulting in the u	nderlying cause g	iven in Part I.			oute to the cause of death?
Vital Records,	w requir been si should		- Myperservin	DIS.				1 □ Y€		
ec	ne law i has be ge 2 sh	Completed	Invetes	mekanis				24a. Was ai autops	y 24b. We	ere autopsy findings available or to completion of cause of
<u>=</u>		Con						perform 1□ Yes 2	ned? de No 1E	ath? □Yes 2□ No
Vita	sician: The certificate harector, page	Be	25. Was case referred to medical examiner?	Hospital:		10	1	ath (Check only on		
or	Physician: r this certificanal director,	2	1 Yes 2 No 27. Manner of Death	1 ☐ Inpatier		II 3 DOA	Val Nursing i	dome 5 ☐ Reside		
n	ding F	ion	Natural 5 ☐ Pending	(Month, Day		W	ork? □Yes 2□No	Zod. Describe ne	w injury cocurre	
Division	l or Attending after death. Director: After	fical	3 Suicide 6 Could not be	28e. Place of inju	ry - At home, farm, st			28f. Location (St	reet and Number	or Rural Route Number,
D	al or after	Certification:	4 ☐ Homicide determined	building, etc	. (Ѕресіту)			City or Town	i, State)	
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	edical C	29a. Certifier Certifying Ph	ysician: To the best on hiner: On the basis of	of my knowledge, deat examination and/or in	th occurred at the	time, date and place	e, and due to the ca	ause(s) and man	ner as stated.  nd due to the cause(s)
	the Hin 24 the F	ledi	one)	and manner sta	ted.		nse number		<u> </u>	(Month, Day, Year)
	with 70 cor	Σ	29b. Signature and title of chiffer	y		17	75957	2		29.08
		0	11114/	namulated	noth (Horn COs) (To	Drint)	1101		14.	/
			30. Name and address of perso, ho	completed cause of de	eath (Item 23a) (Type,	(CHMAN	S LANG	Ensi	on Mr	21601
	St	ate	31. Date filed (Month, Day, Year)		r's Signature		_ // / / / /	, -110(	-	
			DEC 3 0 2	חתא   אחת	M	To a self a				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Frederick Edward Johnson 12/23/2008 2:30 A /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Mallard Bay Care Center Dorchester Cambridge If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funera' Days Hours 1 M 2 ☐ F 90 214-07-9031 Director 08/23/1918 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location death with the Maryland a or 28a-f show be notified at 10b. County 1 ✓ Yes 2 ☐ No Director Maryland Dorchester Cambridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or Items 23a 8 Talbot Avenue 21613 USA by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ✓ Yes 2 ☐ No If Yes, Give 11 Marital Status Black, White, etc. filed within 72 hours after 1 □ Never Married 2 □ Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1941 1945 Specify: Specify. 3 Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Hardware 12 permit. Pages 1 and 2 should be file.
Department of Health and Mental Hyoi Important: If Item 27 is marked any injury or other to once. 27 is marked other er traumatic event, ti 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Goldsborough Johnson ဂ္ Lena Ruark 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PO Box 92, Rhodesdale, MD 21659 Jean McWilliams / Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 12/27/2008 Cambridge, MD Dorchester Memorial Park 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Curran-Bromwell Funeral Home, P.A., 308 High St., Cambridge, MD 21613 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 0 years Physician advanced disease or condition resulting in death) /Medical Due to (or as a consequence of) Examine Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner that the death certificate be executed and Due to (or as a consequence of): Box 68760. physician Physician/Medical the as attending | | for use as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) signed by the a Records, P.O. 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Jas autopsy 1∐ Yes Division or Vital Physician:

page certificate ! funeral director Be 2 To the Funeral Director; After this completely filled in by the funeral directions Certification: death.

25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA

27. Manne of Death 1 Natural

5 Pending 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of Injury

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only

Medical

State

Registrar

2 Accident

3 ☐ Suicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier akan

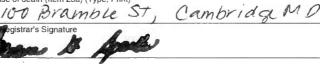
10059973

29d. Date signed (Month, Day, Year) 12/26/08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 Bramble ST Patricia Johnson

31. Date filed (Month, Day, Year)

DEC 3 0



or Attending

To the Hospital hours

within 24

1. Decedent's Name (First, Middle, Last)

Reg. No. 2

2. Date of Death

2

Hospital or Attending

5

Physician: The law requires that the death certificate be executed

Box 68760,

P.0.

Division of Vital Records,

filed within 72 hours after death

Baltimore, Maryland 21215-0036

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) 2008



and manner stated

30. Name and address of person with completed cause of death (Item 23a) (Type, Print)

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Medical

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D64502

29d. Date signed (Month, Day, Year)

20850

Dec. 29, 2008

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death **Physician** Month Dolores Jeter December 2008 1:20 A.M 28, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 418 Carrollton Drive Frederick Frederick If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number Birthplace (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Days Voorl Hours 1 □ M 2 X F Director 296-38-3546 63 Sept 6,1945 Ohio Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Evaniant a ust be mathed at Maryland | Montgomery Germantown Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 13301 Neerwinder Place 20874 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X 1 Yes 2 □ No If Yes, Give Year or Dates: 1963–66 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2**X**XNo Specify Specify: **Black** 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry within 72 Elementary/Secondary (0-12) College (1-4or 5+) 2 should be filed withi and Mental Hygiene. Personnel Mgt. Specialist Government Federal 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) æ permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev James F. Jeter Roberta Hudson 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Delores DeLauder/Caregiver 418 Carrollton Drive, Frederick, MD 21701 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ➡ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) VA National Cem Dayton, OH Jan 5, 2009 22. Name and Address of Facility Stauffer FuneralHome, PA 21. Signature of Funeral Service 1621 Opossumtown Pike, Frederick, MD 21702 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** OVARIAM /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of) Box 68760, Physician/Medical the attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Year 5 Other (specify) P.0. ed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 🗌 Yes 3 Probably 4 Unknown Completed 2 No page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 has autopsy certificate 1 ☐ Yes After this certification 25. Was case referred to medical examiner?
1 ☐ Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 NOther (Specify) Caregivers Home Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending To the Hospital or Attendir within 24 hours after death. To the Funeral Director: A completely filled in by the fu investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Deficial Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier elli 9 39. Name and address of person who completed cause of death (Item 23a) (Type, Print) WRTIRE CHURY LIVE LANGE 1020707 15 DOELLA M 832 31. Date filed (Month, Day, Year) 32. Registrar's Signature DEC3 0 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year Paike 25, 2008 8:42 /Medical December 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Crofton Convalescent & Rehab. Center Crofton 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) NOV. 23, 1 Birthplace (State or Foreign Country) **Funeral** 1 M 2 K Days Hours 174-26-8379 1928 Estonia Director 80 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in then "naturel", or Items 23e or 28a-f show Completed by Funeral Director 1 ☐ Yes 2 ☑ No Anne Arundel Crofton MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1581 Fallowfield 21114 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene-Importent: If item 27 le marked other then "naturel", or Iten eny linjury or other treumatic event, the Modical Exercited Once. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify. 3 StWidowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Helmi Troonberk Georg Viinamagi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1738 Copley Ct. Hille Peterson / daughter Crofton, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4 Donation Bayview Crematory 12/26/2008 | Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy. Bowie, MD 20715 23a. Part1. Enter the dise se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** B-CELL LYMPHOMA MONTH /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that in its tool accepts.) Examiner Due to (or as a consequence of): To the Hospitel or Attending Physicien: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 3 ☐ Probably 4 ☐ Unknown 1 🗀 Yes 2. No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2□ No 1 Yes 2 No 1 Tes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other. 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2XNo Certification: To After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funerel Director; 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) illed in by determined 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and the of certifie 29c. License number 29d. Date signed (Month, Day, Year) D66753 12/26/08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Medical Annapolis MD 21401 Tim Capstack 2001 31. Date filed (Month, Day, Year) 32. Régistrar's Signature DEC 2 9 2008

Registrar

DHMH 17 Rev 1/2001

		1 - For State Registrar		State of Ma		partment d <i>ertificate</i>				eg. No.	008	43354
Physici		1. Decedent's Name Irene	e (First, Middle, La	ist)	Kane				2. Date of Dear Month Decembe	Day	Year 2008	3. Time of Death 4:45 A M
/Medic Examir		4a. Facility Name (/	f not institution, gi	ve street and number)		4b. City, To	wn, or Locatio		Decembe		County of Death	)
Exami	eı	Arbor at	Baywood	S		Anna	polis			An	ne Arur	ndel
Funeral Director		5. Social Security N 403-28-9	lumber 6.		(In yrs. last birthd	ay) If Under 1		der 24 Hrs. s Min.	8. Date of Birth (Month, Day) May 25	Year) 1918	9. Birth Cou	place (State or Foreign intry)
nyland show		Usual Residence of 10a. State	Decedent 10b. County		10c. City, Town o	r Location						10d. Inside City Limits 1 ☐ Yes 2 XNo
e Ma	cto	MD	Anne Ar	rundel	Annapo:							
ith th	Dire	10e. Street and Nu				10f. Zip Co			1	0g. Citize	en of What Cou	untry?
s 23a	rai		ayFront 1		in a line of the l	214		Origin? (Spe	oifu Vac ar No	14	USA 4. Race - Amer	ican Indian
III ( Z I Z I 3-0030 be filed within 72 hours after death with the Maryland tial Hygiene. Ad other than "natural", or liems 23a or 28a-1 show event, the Marical Exa offer must be notified at	by Funeral Director	11. Marital Status 1 ☐ Never Marr 3 ☐ Widowed	ied 2 Married 4 □ Divorced	12. Was Decedent E Armed Forces? 1 Tyes 27 N If Yes, Give Year or Dates:	0	I3. Was Deceden If Yes, specify  1 ☐ Yes 2X			Rican, etc.)		Black, White	
72 ho	ted	(Snec	15. Decedent's E	ducation	16a. De	ecedent's Usual (	Occupation	nost of workin	10	16b. Kind	d of Business/li	ndustry
thin 7	Completed	Elementary/Seco	ondary (0-12)	College (1-4or 5	+)	ive kind of work of e. DO NOT use	retired)	7001 01 11071111	.9	Ωv	vn Home	
filed wither th	Con	1:	-	04	Ho	memaker	40.14-		(First Middle			
0 ~	Be	17. Father's Name			Wed at				(First, Middle, I	Maiden S		1
should be nd Mental marked c	2	Freder:		F.	Voigt	ailing Address (S		nes	/ Pauta Numba	City or	Holbre	
, Mal				ker Daughte	r 17	25 Tarri	ngton	Place	Crofton	n,MD	21114	
DESILITIONE, INITY JEEP Permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce.		<sup>¹</sup> 4 □ Donation	Cremation 3 5 ☐ Other (Spec		cemetery,	sposition (Name crematory or othe c Cremat	er place)	12/23			ation - City or I	
permit. Departi		21. Signature of F	herai Service Lic	hypo		22. Name and A	Address of Fac y Funei	ral Ho	me P.A.	12	Ridgely	Ave Ann, MD
Pnysician /Medical Examiner	er	shock, or hea Immediate Cause disease or condition resulting in death)  Sequentially list or if any leading to it	art failure. List onl (Final on onditions,	Due to (or as a	the death. Do not e.  Zhe!  a consequence of)	mer				est,		Approximate Interval Between Onset and Death
<b>68 / 60,</b> ficate be executed physician and is the burial-transit	edical Examiner	Cause (Disease or that initiated event resulting in death)	S	c.  Due to (or as a	a consequence of)							
death certif	Physiclan/Med	IF FEMALE: 23b. Was deceder in the past 12 1 □ Yes 2 9 □ Unknown	months?	23c. If yes, outcome 1□Live birth 4□Pregnant at 9□ Unknown	2 🗌 Fetal death	3 □Ectopic preg 5 □ Other (spec				23	3d. Date of deliver Month	very Day Year
ires that signed by d be deta	b	Part II. Other signi	ficant conditions	contributing to death bu	ut not resulting in th	ne underlying cau	ise given in Pa	art I.	23e. Did to			the cause of death?
The lay ate has page 2	Completed								24a. Was a autops perfor	ın	24b. Were aut prior to o death?	topsy findings available ompletion of cause of
r VITA ysician: is certific director,	Be (	25. Was case refe examiner?	rred to medical						(Check only or			
VISION OT VITA Attanding Physician: or death. ector: After this certific. by the funeral director,	2	1 ☐ Yes 2			nt 2□ER/Outp				ne 5 🗆 Resid			uty)
ding P	on:	27. Manner of Dea 1 Natural	5 Pending	28a. Date of Injui (Month, Da)		ry	Work?		28d. Describe h	ow injury	occurred	
Vitandii death. ctor: A y the fu	cat	2 Accident	investigati 6 ☐ Could not	he	At hama farm	M	1 ☐ Yes 2	_	29f Location /C	troot and	Number of Pu	ral Route Number,
DIVISION Ospital or Attanding hours after death. uneral Director: Afte	Certification;	4  Homicide	determine		ury - At home, farm c. (Specify)	, street, factory, (	опісе		City or Tow		Namber of Ha	rai noute ivumber,
DIVI  To the Hospital or Al within 24 hours after or To tha Funeral Direct completely filled in by	-	29a. Certifier (Check only one)	1 Certifying I 2 Medical Ex	Physician: To the best of aminer: On the basis of and manner sta	of my knowledge, o examination and/ ited.	leath occurred at or investigation, in	the time, date n my opinion, d	and place, a death occurre	and due to the c ed at the time, d	ause(s) a late and p	and manner as place, and due	stated. to the cause(s)
To ti withi To ti	M	29b. Signature and	auditile of certifier	Service of the basis of and manner state of the service of the ser	MD	29c. t	C O 2	295	71	29d. Date	signed ( <i>Month</i>	Day, Year)
#3		30. Name and add	3, Bel	o completed cause of d	eath (Item 23a) (Ty	efens	e Hu	wy,	Cro-	fto	n, mo	21114
St Regist	ate rar	31. Date filed (Mo	DEC 2	9 2008 32. Registra	ar's Signature	park	1					

WIL 17

430-State

29b. Signature and title of certifier

9

29c. License number 43643 29d. Date signed (Month, Day, Year)

12-29-08

217も3

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TAGE , uno. Frederick 4

TANENTOW

31. Date filed (Month, Day, Year) 32. Registrar's Signature 2008

Registrar

08-09793 Timothy K. Kelly

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 L	3	3	5	5
--------	---	---	---	---

	-	- For State	Certificate of	Death		Reg. I	No.	00 4000
Physiciar Medical Examin	1/ 1	Decedent's Name (First, Middle,Last)	edent's Name (First, Middle,Last)					
		Timothy Kirstin KELLY  4a: Facility Name (if not institution, give street and numl  345 North Potomac Street	per) 4	b. City, Town, or L Hagerstown	ocation of Death		4c. County of Dea Washington	ith
Funeral Director	- I-	5. Social Security Number 6. Sex 7. 213-68-6047 1X M 2 F	Age (In yrs. last birthday)  53 Yrs.	If Under 1 Year Months Days	If Under 24Hrs. Hours Min.	8, Date of Birth(N	MM/DD/YYYY) g. E	
žue.	-	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Location	on	l			10d. Inside City Limits
<b>*</b> .	횽	Maryland Washington	Hagerst	OWN 10f. Zip Code	<del> </del>	10g.	Citizen of What Co	1 X Yes 2 No
ith the Maryfand 23a or 28a-f sho notified at once	al Director	345 North Potomac Stre	e <b>t</b> lent Ever in U.S. 13. Was	217 s Decedent of Hisp	740	ecify Yes or No-	IJSA 14. Race - Am	erican Indian, Black,
er death w , or items	Fune	1 Never Married 2 Married Armed Ford 1 Yes 3 Widowed 4 X Divorced If Yes Give Year	ces? If Ye	es, specify Cuban, Yes 2 X No	Mexican, Puerto	Rican, etc.)	White, etc.	hite
AD 21215-0036 2 should be filed within 72 hours after death with the Maryfand h and Mental Hygtene. 27 is marked other than "unatural", or items 23a or 28a-f she matic event, the Medical Examiner must be notified at once	ted by	15. Decedent's Education (Specify only highest grade  Elementary/Secondary (0-12) College (1-4)	completed) 16a. Decedent	t's Usual Occupationst of working life.	on (Give kind of w		6b. Kind of Busines	
.0036 within 72 giene. her than '	Completed	12 2	Cle		8.Mother's Name	(First, Middle, Mai	Retail den Surname)	
ore, MD 21215-0036 ss 1 and 2 should be filed within 7 of Heafth and Mental Hygiene. If item 27 is marked other than ther traumatic event, the Medica	B B	Edward Lewis Kelly  19a. Informant's Name/Relationship (Type, Print)	19b. Mailing	Address (Street	Ruth E	lizabeth Rural Route Numbe	Lehman er, City or Town, Sta	ate, Zip Code)
		Michael Kelly - Brothe:			Cedar Co	Durt, Cha	ntilly 20c. Location - City	VA. 20152 or Town, State
Pag nent		1 Burial 2 X Cremation 3 Removal from 4 Donation 5 Other Specify:	Hagerstown	n Cremat				n, Maryland
	- î	21. Si e of Funeral Service Licensee	ne 2   41	lame and Address	son Blvd	l. Hagers	Tuneral H	
Physician 'Medical caminer		This could be a second of the	ral hemorrhage	ne mode of dying,	Such as cardiac o	·	, shock, of freat	Between Onset and Death.
	_	Sequentially list conditions, b	consequence of):					
	Examine	cause. Enter Underlying Cause	consequence of):					
execular and and all - tra	/Medical E	d. UNPENDED AMENDED						
Box 68760, e death certificate be the attending physicied for use as the buried for the buried for use as the buried for use as the buried for the bur	Physician/Me	23b. Was decedent pregnant in the past 12 months?	nt at time of death 5 Ot	etal death 3 [	Ectopic pregna	ancy	23d. Date of delive Month	very Day <b>Y</b> ear
O. Bc nat the dea ed by the a	by Phys	Part II. Other significant conditions contributing to		underlying cause g	given in Part I.			to the cause of death?
tal Records, P.O. Box 68 cian: The law requires that the death certificate has been signed by the attending ector, page 2 should be detached for use as		Chronic alcohol abuse				24a. Was an	24b. Were	autopsy findings available to completion of cause of
Vital Recolysician: The law	Completed			26 Place	of Death (Check	perform 1 <b>Y</b> Yes 2	ed? death	
ician:	a	25. Was case referred to medical examiner?	patient 2 ER/Outpatient		Othor		esidence 6 🗸 O	ther: Scene
Division of Vital Records, P.O. the Hospital or Attending Physician: The law requires that the him 24 hours after death.  the Funeral Director: After this certificate has been signed by applicitly filled in by the funeral director, page 2 should be detach	ion: To	27. Manner of Death  1 Natural 5 Pending FOUND:	of Injury 28b. Time of I FOUND:	Injury 28c. Inju	ry at Work? Yes 2  No	28d. Describe ho Subject fell	w injury occurred	
Division of N To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Medical Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specific)	2008   1706 hrs of Injury - At home, farm, stre Multi-Family Apt.	et, factory, office t	ouilding, etc.		reet and Number or ite) nac street, Hage	Rural Route Number, City
Hospi 24 hou Funer fely fil	ical Ce	29a. Certifier (Check only one) 2 Medical Examiner: On the basis one)	of my knowledge, death occu	rred at the time, dation, in my opinion	ate and place, and	due to the cause	(s) and manner as	stated.
To the within To the comple	Med	29b. Signature and title of certifier	ated.	29c. Licens			29d. Date signed December 29	
		30. Name and address of person who completed caus Zabiullah Ali, M.D. Assistant Medica	e of death (Item 23a)	nn Street, Balt				
15H-2 st	ate	31. Date filed (Month, Day Year) 32. R	gistrar's Signature	arke				
Regist		14N 0.5 70091 /2	eneva p. A.	-				

**ORIGINAL** 

			1- For Amend Items 23,27,28a-r per me, 1 Registrar Cer										
178	Physicia	an	1. Decedent's Name (First, Middle, Last)	2. Date of Month DECEMB	Day Year								
	/Medic Examin	. 1	MARILYN S. LEECH  4a. Facility Name (If not institution, give street and number)	4c. County of Death									
7	Examili	e:	FOREST HILL HEALTH AND REHABILITATION	FOREST HILL	HARFORD								
**	Funeral Director		5. Social Security Number 212-26-1659 6. Sex 79 7rs. 7 Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Office 24 Hrs. 6. Days Hours Min. 03/13/1929 9 PENNSYLVA										
1177	land ow it		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Loc	ation	10d. Inside City Limits								
	a-f sh	ctor	MD BALTIMORE MONKT	NC	1 ☐ Yes 2 No								
	ith the	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?								
	eath w	Funeral	16 105 CARROLL RD  11 Marital Status 12, Was Decedent Ever in U.S. 13. V	21111 Vas Decedent of Hispanic Origin? (Specify Yes or	USA  14. Race - American Indian,								
5-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hyglene. Item 27 Is marked other than "natural", or items 23a or 28a-f show item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	1 □ Never Married 2 □ Married 1 □ Yes 2 ☑ No	Vas Decedent of Hispanic Origin? (Specify Yes or Yes, specify Cuban, Mexican, Puerto Rican, etc.)  ☐ Yes 2 No Specify:	Black, White, etc.  Specify: WHITE								
2-0	72 ho "natur dical	eted	(Specify only highest grade completed) (Give I	ent's Usual Occupation kind of work done during most of working IO NOT use retired)	16b. Kind of Business/Industry								
2121	filed within Hygiene. rther than '	Completed	Flementary/Secondary (0-12)   College (1-4or 5+)	PHONE CO. REP.	C&P TELEPHONE								
d 2	other other	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Mid	dle, Maiden Surname)								
ylar	2 should be and Mental Is marked c	일	UNKNOWN										
Baltimore, Maryland	and 2 sho ealth and n 27 Is m			g Address (Street and Number or Rural Route Nu  CARROLL RD MONKTO									
	age ento tt: if y or		1 M Burial 2   ICremation 3   IHemoval from State	of the part of the	20c. Location - City or Town, State BALTO • , MD •								
Balti	permit. Par Departmen Important: any Injury once.		21. Signature of Funeral Service Licensee	Name and Address of Facility ENRY W. JENKINS & S 6924 YORK RD MONKTO	ONS CO.								
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):	er the mode of dying, such as cardiac or respirator	y arrest,  Approximate Interval Between Onset and Death								
68760,	ficate be executed physician and s the burial-transit	Physician/Medical Examiner	edical	edical	edical	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	Tule OFFICION APPROVEDE	AMEDICAL EXAMINER					
P.O. Box 6	iaw requires that the death certific as been signed by the attending p 2 should be detached for use as					ysician/Me		Ectopic pregnancy Other (specify)	23d. Date of delivery  Month Day Year				
	quires that n signed by uld be deta	by	Part II. Other significant conditions contributing to death but not resulting in the un		id tobacco use contribute to the cause of death?  ☐ Yes 2 ☐ No 3 ☐ Probably 4 ဩUnknown								
or Vital Records,	The law requir ate has been si page 2 should	Completed	,	24a. V a p 1   Y	utopsy prior to completion of cause of death?								
/ita	Physician: The this certificate har all director, page	Be	25. Was case referred to medical examiner?  **Type:   Hospital:   Type:   Control   Co	26. Place of Death (Check or									
or	<b>ਦ</b> # E	<u>۲</u>	27. Manner of Death 28a. Date of Injury 28b. Time of		esidence 6 Other (Specify) be how injury occurred								
ion	Attending Phrdeath. ector After the by the funeral	ation	Natural 5 Pending (Month, Day Year) Injury 2 Accident investigation 11/06/2008 2:00a		ect fell down stairs.								
Division	5 월 등	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of injury - At home, farm, strue building, etc. (Specify)  Home	City or	n (Street and Number or Rural Route Number, Town, State) 16105 Carroll Rd. on, MD								
	To the Hospital within 24 hours and the Funeral completely filled	Medical (	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death of the										
	To th To th comp	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)								
		63	Dowl 5 D	D32241	December 15, 2005								
-			30. Name and address of person who completed cause of death (Item 23a) (Type, DR. DAVID DUNN 615 W.MACPHAIL ROA		21014								
	Sta Regist		31. Date filed (Manth, Day 2009 232. Registrar's Spnature)										

		•	For State Registrar	Olato of Mil	ai yiai ia 7	•	tificate of l				2008	43358	
	Physici	an	1. Decedent's Name (First, Middle, La						2. Date of De Month	D	ay Year	3. Time of Death	
	/Medic		Richard	4. 63. 7.	Large of Day	28		4:53 A M					
	Examin	er	4a. Facility Name (If not institution, giv		4b. City, Town, or Westmi		atri	40	4c. County of Death  Carroll				
market !			Dove House  5. Social Security Number 6. 5	birthday)	If Under 1 Year		s. 8. Date of Bir	th		nplace (State or Foreign untry)			
	Funeral Director			INTM 2□ E	84	Yrs.	Months Days	Hours Mir	8. Date of Bir (Month, Da 05-17-	19, Year -192	24 ME	intry)	
	land ow											10d. Inside City Limits	
	Mary R-f sh	ż	MD Howard	3	E11:	icott	City					1 ∐Yes ޶ No	
	h the	irec	10e. Street and Number				10f. Zip Code			10g. C	Citizen of What Co	untry?	
	th wil	Funeral Director	9094 Northfield	Road			2104				Jnited St		
	r dea	nue	11. Marital Status	12. Was Decedent Armed Forces?		13. W	las Decedent of H Yes, specify Cuba	ispanic Origin? ( ın, Mexican, Pue	(Specify Yes or No erto Rican, etc.)	)-	14. Race - Ame Black, White		
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, It is "die I Evar; incl. in the institute and once.	Completed by F	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	1 Tyes 2 X If Yes, Give Year or Dates:	No	1	□Yes 2⊠No	Specify:				ite	
5-(	72 h "natu dical	ete	15. Decedent's E (Specify only highest gra	ducation ade completed)	16	6a. Deced	ent's Usual Occup kind of work done o O NOT use retired	ation during most of w	orking	16b.	Kind of Business/I	ndustry	
12	within ene. than	щ	Elementary/Secondary (0-12)	College (1-4or 5	5+)		lechanic	1)			Power To	v1s	
d 2	filed Hygi other ent, t		17. Father's Name (First, Middle, Last	·)		T.	icci ani ic	18. Mother's Na	ame (First, Middle			<i>7</i> 010	
lan	ld be fental ked (	To Be	Leonard Lanciott	i				Lucia '	Trulli				
Maryland	2 should be filed within 7 h and Mental Hygiene. 7 is marked other than "traumatic event, I have		19a. Informant's Name/Relationship								or Town, State, Z		
	1 and 2 Health em 27 b		Kathy L. Jestes/	Daughter					llicott		, MD 210		
Baltimore,	of H		20a. Method of Disposition  1 M Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place ceme	of Dispos etery, crem	sition (Name of vatory or other plac		Date		Location - City or		
Ë	: Pag tment tant: jury o		4 Donation 5 Other (Specify) Good Shepherd Cem. 12-31-2008 E								Cllicott City, MD		
Bal	permit. Pages 1 Department of H Important: If ite any Injury or ot		21. Signature of Funeral Service Licensee M01044 22. Name and Address of Facility Harry H. Witz										
			23a. Part 1. Enter the disease, or con shock, or heart failure. List only	nplications that caused	the death. D	o not ente	er the mode of dyir	ng, such as cardi	iac or respiratory a	rrest,		Approximate Interval Between	
4	Physician		Immediate Cause (Final disease or condition										
20	/Medical Examiner		resulting in death)	Due to (or as	a consequenc	ce of):							
	LXammer	j.	Sequentially list conditions,	b	a consequenc	re of):							
	uted I Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	240 (0) 40	a concoquent	30 01/1							
Ć.	exection and ital-tra	Еха	resulting in death) Last	c Due to (or as	a consequenc	ce of):							
68760,	ficate be executed physician and s the burial-transit	<b>Aedical</b>	•	d									
_	ertifica ing ph as th	Med	IF FEMALE:										
O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome  1  Live birth 4  Pregnant a	2 Fetal dea	ath 3□	Ectopic pregnanc Other <i>(specify)</i>	у			23d. Date of del Month	ivery Day Year	
σ,	signed by		Part II. Other significant conditions	contributing to death b	out not resulting	g in the un	derlying cause giv	en in Part I.	23e. Did 1	tobacco	o use contribute to	the cause of death?	
rds	quires en sign uld be	ed by							1 🗆	Yes	2 □ No 3 1 Pr	obably 4 ☐ Unknown	
Records,	aw requir as been s 2 should	Completed							24a. Was		24b. Were au	topsy findings available completion of cause of	
Ä	The late has	E O								rmed?	death?		
Vital	ctor,	Be C	25. Was case referred to medical examiner?						eath (Check only o				
of \	hysic this c	ဥ	1 Yes 2 No		ent 2 ER/			4 LI Nursing				oity) DOVE HOUSE	
n C	ding Physician: The law n After this certificate has funeral director, page 2 ?	27. Manner of Death 1 Natural 5 Pending (Month, Day, Year) 28b. Time of injury Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury of injury M 1 Yes 2 No								ury occurred			
Division	or Attencatter death Director:	licat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not to		jury - At home,	, farm, stre	eet, factory, office	7es 2 🗆 140	28f. Location (	Street	and Number or Ru	ıral Route Number,	
Ö	safter safter	Certi	4 Homicide determined	building, e	tc. (Specify)				City or To	wn, Sta	ite)		
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifical completely filled in by the funeral director, is	Medical Certification: To	(Check only 2 Medical Exa	hysician: To the best miner: On the basis and manner st	of examination	and/or inv	vestigation, in my o	opinion, death oc	curred at the time,	date a	and place, and due	to the cause(s)	
	To th withir To th comp	Me	29b. Signature and Jugof certifier				29c. Licens	e number		29d. D	Date signed (Monti	n, Day, Year)	
	H		and manner stated.  29b. Signature and put of certifier  29c. License number  MD 43 4235  30. Name and addless of person who completed cause of death (Item 23a) (Type, Print)  MOHIT NARWG 555 S. (Lenter St. Westminster MD  31. Date filed (Month, Day, Year)  32. Registrar's Signature  A facel										
	8.0		30. Name and addless of person who	completed cause of	death (Item 23	(Type, I	S. Cent	ter St.	Wester	1111	ster M	10	
4	St: Regist	ate rar	31. Date filed (Month, Day, Year) UEC 3 0	2008 32. Regist	rar's Signature	1 1	backel			3			

DHMH 17 Rev 1/2001

parks

amen aaco	d line hlth	e d	26 per m ept 12/3	ne <b>Plea</b> 80/08	se Type dlw <sub>Sta</sub>	or Pr	int in E	Black I	<b>ndelibl</b> partme	e Ink	. <b>Ens</b> Health	sure A	II Copie	s Are	Legi	ble.	
			1 - For State Registrar					C	ertifica	te of	Deat	h		Reg. No	20	08	43359
	Physici	an	1. Decedent's Nam											2. Date of Death			3. Time of Death
	/Medic		Joa				E11wc	ood		Lowr			Decemb	er 20	, 200	Year 8	3:28 P M
9	Examin	ner	4a. Facility Name (If not institution, give street and number) Southern Maryland Hospital						C1	4b. City, Town, or Location of Death Clinton			Prince G			Georg	
	Funeral Director		5. Social Security Number 6. Sex 1 1				ige (In yrs. 72	last birthda Yrs.	Months	Days	Hours	er 24 Hrs. Min.	8. Date of B Month, I May 6	Birth Day Year) 1936		9. Birthp	place (State or Foreign office) Ashington, DC
			Usual Residence of										122) 0,	, 1750			Zarrigeon, be
	arylan show dat	_	10a. State   10b. County   10c. City, Town or Location     Maryland   Prince George's   Camp Springs										1	0d. Inside City Limits			
	the M	ectc	Maryland  10e. Street and Nu		George :	S 		Camp S		p Code				T 10- 0		115-4-0	1 □Yes 2XXNo
	3a or	al Di	5719 Mid		ane					0748					USA	Vhat Coun	try?
336	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: I fleem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It a INvoical Examinar mast be notified at once.	by Funeral Director	11. Marital Status 1 ☐ Never Marri 3 ☐ Widowed		ried 1 If Ye	s Deceden ned Forces ]Yes 2X es, Give ar or Dates	] No	.S. 13	3. Was Dece If Yes, spe 1 ☐ Yes				ecify Yes or N Rican, etc.)	lo-		k, White, e	
2-0	72 hou	ted	(Cno.	15. Deceden	t's Education			16a. Dec	edent's Usu	ual Occup	oation			16b. K	ind of Bu	siness/Inc	lustry
Baltimore, Maryland 21215-0036	vithin 7	Completed by	Elementary/Seco		st grade comp.	<i>letea)</i> lege (1-4or	5+)	life	ve kind of wo DO NOT L Homema		during mi d)	ost of work	ing		In H	loma.	
d 2	filed v Hygie other t	ပ္ပိ	17. Father's Name	(First, Middle,	Last)				nonen	ikei	18. Mot	ther's Name	e (First, Middle	e. Maiden			
an	ild be fental rked c iic eve	To Be	Francis									earl	Renner	-,		0)	
ary	shou and N s mai	_	19a. Informant's Na	ame/Relations	hip (Type. Prir	nt)		19b. Ma	iling Addres	s (Street	and Num	nber or Run	al Route Num	ber, City o	or Town,	State, Zip	Code)
Σ.	and 2 lealth m 27 i		_Robert Lo		sband		.,					e Camp	Springs,	, Mary	land	2074	<del>1</del> 8
lore	ges 1 nt of H if iter or oth		20a. Method of Disp 1 ☐ Burial 2		3 ☐ Removal	I from Salate	<b>=</b> 1		position (Na ematory or	me of other plac			Date			City or To	,
i ii	nit. Pa artmer ortant: njury		4 ☐ Donation 21. Signature of the			//	Kal		matory 22. Name a	wed A alutes			3/2008	'			-
Ва	Physician /Medical Examiner		21. Signature of u	Ineral Service	Licensee	4						O.C.	orge P.	Kalas Marvl	Fune and	ral Ho 20745	
		6 9	23a. Part / Enter the disease, or complications that paysed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate														
P			Shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, heading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):									Onset and Death					
		_	Sequentially list cor	nditions,	b	Ly 1	rail	الدور				1	3	98	_		
7		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  b. Due/td/(or as a consequence of):  c														
o,	e executed ian and irial-transit	Еха	that initiated events resulting in death) I	Last	c	ue to (or a	s a consequ	uence of):		Doll	JF	* /					
)9/	ite be nysicia ne bur	ical			d				,	P.							
89 3	ing pt	Med	IF FEMALE:														
Division of Vital Records, P.O. Box 6876	within 54 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the buri	Physician/Medica	23b. Was decedent in the past 12 1 ☐ Yes 20 9 ☐ Unknown	months? XINo	1 4	Live birth	e of pregna 2 ☐ Fetal at time of d	I death 3	☐ Ectopic p☐ Other (s		у			1	23d. Date Mor	e of delive nth	ry Day Year
S, F	igned be det	by P	Part II Other signif				n ,	- /	underlying o	cause give	en in Parl	t I.	23e. Did	tobacco u	se contr	ibute to the	e cause of death?
ord	inhai eeu si uonid I	ted	Chrone Obstructure Juliway Ossess 10 Yes							Yes 2	es 2 No 3 Probably 4 Unknown						
3ec	has b	Completed	Walnuty	, muce	indes	<i>I</i> -		-					24a. Was	psy	prior to completion of cause of		
<u>a</u>	ficate r, pag		Coron	my Cin	tery 1	au	w						perfi 1 □ Yes	ormed? 2 ☑ No	d	eath? □Yes	2 □ No
× ×	niscertificate has t director, page 2 s	o Be	25. Was case referrexaminer? 1 Yes 2 □	red to/medical No	Hospital:	1 N Innat	iont o'N	ED/Outpati	ent 3 □ D0	Othe			(Check only				
ا و	grriny ter this neral o	ŭ.	27. Manner of Death	h		Date of Inj (Month, D	urv	28b. Time		28c. Injury Work			me 5 🗆 Res 28d. Describe				ell est
sior andin	or: Af	atio	1 □ Natural 2 Accident	5 ☐ Pendin- investiç	ation Dec	ente 200	r (7	Injury UN KN	DUM		<br Yes 2-€	₹No /	NUPSIO	y L	oma		
)ivis	ifter de Directe in by t	Certification: To	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could r determ		Place of In		me, farm, s	treet, factor	y, office		1	28f. Location City or To	(Street and	Number	r or Rural	Route Number,
	ours a	S	29a. Certifier	1√√ Certifyin	g Physician:	N W/		wledge dea		l at the tir	me date		KOALL	Clin	stow.	MA	y Cons of
Ž Ž	n 24 h	edical		2 Medical	Examiner: On	the basis I manner s	of examinat	tion and/or	investigation	n, in my o	pinion, de	eath occurr	ed at the time	, date and	place, a	nd due to	the cause(s)
‡ •	within comp	Me	29b. Signature and	title of certifier					29	icense	e number	,		29d. Dat	e signed	(Month, E	Pay, Year)
			P A	Mucas	de					143	276	0		Du	en	by -	22, 2008
CA	13		30. Name and address	. 080	who completed	cause of	death (Item	0 6 0 6	Print)	~ N	rand	Und	M	) 2	017	V	
	Stat Registra		31. Date filed (Mont	DEC 2	3 2008	32. Regist	rar's Signat	A.	park	1							

08-09865 Sandy Lester Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

andy Lester		State of Maryland / Department of Certificate of Registrar		nd Mental I		eg. No. 200	18 43361				
Physician Medical Examina	7	1. Decedent's Name (First, Middle, Last) Sandy Lorraine Lester			2. Date of Deat Month December	Day Year	3. Time of Death 0903 hrs				
neulcal Examine		4a. Facility Name (if not institution, give street and number)	4b. City, Town, o	or Location of Dea		4c. County of Dea					
		7867 Americana Circle  5. Social Security Number	Glen Burni		Irs 8 Date of Bir	Anne Arunde					
Funeral Director	- 1	220 07 1561 X 39	Months Da		12/13	, Eoro					
any		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Loc	cation				10d. Inside City Limits				
*	_	Maryland Anne Arundel Glen Bur	nie				1 Yes 2 X No				
te Maryland or 28a-f show filed at once.	DIrector	10e. Street and Number	10f. Zip Code		1	0g. Citizen of What Co					
1 with the Maryli ms 23a or 28a-f be notified at o		202 Willow Lane  11. Warital Status 12. Was Decedent Ever in U.S. 13. V	21061 Was Decedent of F	Hispanic Origin? (	Specify Yes or No	United S	erican Indian, Black,				
death w	Funeral	Armed Forces?  1 Yes 2 X No	f Yes, specify Cub	an, Mexican, Pue		White, etc.					
ral",	≥ -	or Dates:	Yes 2 X N		of work done	Specify: Wh:					
7 3 -	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	most of working li			-1 -1					
15-0036 filed within 72 l'Hygiene. ed other than "	d lo	10 Home  17. Father's Name (First, Middle, Last)	maker	18 Mother's Na	me (First, Middle,	Home  Maiden Surname)					
	Be C	Kenneth Edwin Lester		Peggy	Darlene	Hunt					
imore, MD 2121 Pages I and 2 should be finent of Health and Memaliant: If item 27 is marked by confer traumatte even.						nber, City or Town, Sta					
ore, MD ss 1 and 2 sho of Health and Friem 27 is her traumath	-	20a. Method of Disposition 20b. Place of Disposition	position (Name of o	cemetery,	Date	20c. Location - City					
Pages   Pages	1	4 Donation 5 Other Specify:	other place) rematory			Edgewater					
Baltimore, permit: Pages I at Department of He Important: If the injury or other tr	1	21. Signature Funeral Service Licensage 22		-	_	Kalas Fun	eral Home r, MD 21037				
Physician	1	23a. Part. Enter the disease, or complications that caused the death. Do not enter	er the mode of dyin	ng, such as cardia	c or respiratory an	est, shock, or heart	Approximate Interval Between Onset and				
Medical xaminer		faffure. List only one cause on each line.  Immediate Cause (Final disease a. Fentanyl and alcoh	ol intox	ication			Death				
		or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions,  b.		12							
	iner	if any, leading to immediate  Due to (or as a consequence of):									
ted 1 nnsit	Examiner	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):									
Division of Vital Records, P.O. Box 68760, note the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	edical	X UNPENDED AMENDED 23a,27,28a-f, per ME g888 2/6/09 TT									
8760, iffcate be ag physic is the burn	n/Me	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2	Fetal death	3 Ectopic pre	gnancy	23d. Date of deliv Month	ery Day <b>Y</b> ear				
Box 6876( e death certificate the attending phy- ed for use as the b	Physician/M	past 12 months?  1 Yes 2 No 9 V Unknown g Unknown	Other (Specify)								
that the de ned by the detached i		Part II. Other significant conditions contributing to death but not resulting in the	ne underlying caus	se given in Part I.		obacco use contribute					
Division of Vital Records, P.O. Ital or Attending Physician: The law requires that the range death.  Find Director: After this certificate has been signed by the funeral director, page 2 should be detacted in by the funeral director, page 2 should be detacted.	ed by				1Ye	es 2 V No 3 P	autopsy findings available				
Vital Records, ysicinn: The law requir his certificate has been so director, page 2 should	Completed			<del></del>	auto perfe	psy prior to ormed? death	o completion of cause of ?				
tal Rec		25. Was case referred to medical	26.Pla	ace of Death (Che	1 Yes	2 No 1	Yes 2 No				
Vita hysicia this ce	To Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpat			ursing Home 5	Residence 6 🗸 Ot	her: Scene				
n of \nding Phy.i After the funeral		27. Manner of Death  1 Natural 5 Pending  7. Matural 5 Pending  1. Natural 5 Pending  1. Natural 5 Pending  1. Natural 5 Pending  1. Natural 5 Pending	· · ·   _	njury at Work? Yes 2 X No	unk	how injury occurred					
Visio or Atter fer deat irrector in by th	Certification:	2 Accident Investigation FG 12/31/VG UTIK 3 Suicide 6 X Could not be	street, factory, offic	ce building, etc.	28f. Location	(Street and Number or State) 7867 Am	Rural Route Number, City				
Div spital o nours af neral D	Cert	4 Homicide determined (Specify)					ericana Cir.				
Division  To the Hospital or Attend within 24 hours after death To the Funeral Director; completely filled in by the	Medical	one) 2 Medical Examiner:On the basis of examination and/or invest	ccurred at the time tigation, in my opin	, date and place, nion, death occurr	and due to the cau ed at the time, date	e and place, and due to	tated. the cause(s)				
or To vici	Me	and manner stated.  29b. Signature and title of certifier		ense number		29d. Date signed (/					
Ciles T		Wolffense Mull	0.	C.M.E.		January 1, 200	99				
1/20		Name and a dress of person who completed cause of death (Item 23a)     Margarita Korell MD.    Assistant Medical Examiner 11 <sup>o</sup>	1 Penn Street,	Baltimore, N	1D 21201						
Sta			barked								
Registi	611	I TORING / UUS I / I ARAME AL AGE SA	COL CO								

		•	State Registrar		Cei	rtificate of	Death	Reg	g. No.	
		9	1. Decedent's Name (First, Middle, Las	t)				2. Date of Death		3. Time of Death
н	Physici		KATHERINE MARI	A LOHMAN				DECEMBER	24, 2008	
9	/Medic Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Death		4c. County of De	ath
			204 STAFFORD ROA	D		STEVE	NSVILLE		QUEEN A	ANNE'S
	Funeral		5. Social Security Number 6. Se	7. Age	(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. E	irthplace (State or Foreign Country)
	Director		216-22-1044	□M 2 <b>X</b> F	79 Yrs.			MAY 3,		SHINGTON, D.C
	pu ,		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	anyla shov dat	<u>-</u>			100. Oily, 10111 01 20					1 □Yes 2 No
	8a-f	Director	MARYLAND CAROI	INE			PRESTON	10	g. Citizen of What	
	vith th	Ë	10e. Street and Number	NEW DOAD		10f. Zip Code	01/55	10		
	s 23s	ral	4469 POPLAR	12. Was Decedent Ev		Was Decedent of H	21655	pocify Vas or No-	UNITED S	nerican Indian,
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:	)	If Yes, specify Cuba 1 ☐ Yes 2 XNo	lispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)	Black, Wi	nite, etc.
ဝို	2 hou	Pg	15. Decedent's Ed	ucation	16a. Dece	dent's Usual Occup	nation	1	6b. Kind of Busines	ss/Industry
715	hin 7; In "n Medi	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+	life.	KING OF WORK GONE DO NOT use retired	during most of worl d)	king		
212	d with giene ar tha the I	E	12			NISTRATIV	E ASSOCIA	ATE	RI	TAIL
	be filed ntal Hygi d other event, tl	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle, M	aiden Surname)	
<u>la</u>	ould by I Ments	5 E	UGHO PEVERINI				ASSU	NTA SCALI	A	
Maryland	2 sho and I s ma		19a. Informant's Name/Relationship (7						City or Town, State	
	os 1 and 2 of Health a item 27 is		KATHLEEN PIERSON/	DAUGHTER			ROAD, ST			AND 21666
ore	0 0 - E		20a. Method of Disposition 1 ☐ Burial 2 【★Cremation 3 ☐	Removal from State	20b. Place of Dispo cemetery, crei	sition (Name of matory or other plac	ce) DECE	1BER 26 2	0c. Location - City	or Town, State
<u>Ĕ</u>	Page ment ant: If ury o		4 □ Donation 5 □ Other (Specify		CHESAPEAR	KE CREMAT	ION 20	)08 s	TEVENSVII	LE, MARYLAND
Baltimore,	permit. Pag Department Important: I any Injury o once.		21. Signature of Funeral Pervice Licen	see HR M	' F		ELFENBEII		NAM FUNER MARYLANI	RAL HOME, P.A 21619
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that caused to	he death. Do not en	ter the mode of dyir	ng, such as cardiac	or respiratory arres	st,	Approximate Interval Between
0	Physician	2.7	Immediate Cause (Final disease or condition	(0)		xaux				Onset and Death
0	/Medical		resulting in death)	a. Due to (or as a	consequence of):	- VIVCEAT	DONCA			3413
	Examiner			- Phi	emonia					4 Days
	4	je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		consequence of):					
	cuted nd ransir	Examiner	mai miliated events	C						
oʻ	ertificate be executed ling physician and e as the burial-transit	Ä	resulting in death) Last	Due to (or as a	consequence of):					
68760,	te be iysicia ne bu	cal		d						
	rtifica ng ph as th	Medical	IE EENALE.							
Вох	0 2 2		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome p 1 ☐ Live birth 2		⊒Ectopic pregnanc	v		23d. Date of o	
Щ.	dea e att	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant at t 9□Unknown	ime of death 5 [	Other (specify)			Month	Day Year
P.O.	The law requires that the death tte has been signed by the atter age 2 should be detached for u	Physician	9 ☐ Unknown					00 5:11-1		
Ś	es th gned be de	by I	Part II. Other significant conditions of	3		nderlying cause giv	/en in Part I.			to the cause of death?
pic	equir sen si ould	ted	ung	Carcir	COMIC			1 Yes	s 2 No 3	Probably 4 ☐ Unknown
Ö	law r as be 2 sh	Completed					·	24a. Was an autopsy	prior t	autopsy findings available o completion of cause of
<u> </u>	ate pag	on						perform 1□ Yes 2	led? death XINo 1 ☐ Y	? es 2□No
/ita	Physician: The this certificate ral director, pag	Be (	25. Was case referred to medical examiner?					th (Check only one	)	D ATTOURNESS
7	S S	은	1 ☐ Yes 2X No	Hospital: 1 ☐ Inpatien	t 2 ER/Outpatie		4 LI Nursing H	ome 5 ☐ Resider	nce 6X10ther (S	DAUGHTERS HOME
0	ng P		27. Manner of Death  1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day		of 28c. Inju Wo	ry at rk?	28d. Describe how	w injury occurred	110111
Division or Vital Records,	Attending r death. ector: After by the fune	Certification:	2 ☐ Accident investigation		1.		Yes 2 No			
Ë	or Att	ŢĮ.	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injur building, etc.	y - At home, farm, st (Specify)	reet, factory, office		28f. Location (Str. City or Town,	eet and Number or State)	Rural Route Number,
	ital c irs af ral D		<b>V</b>	1						
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	cal	(Check only 2 Medical Exar	ysician: To the best of niner: On the basis of	examination and/or ir					
	the thin 2 the mplel	Medical	one) 29b. Signature and title of certifier	and manner stat	ea.	29c. Licens	se number	20	ld. Date signed (Mo	onth Day Year)
	7 × i		250. Signature and title of certifier	. an Cn	. 1	200. 210011			a. Date Signed (MC	
	1.15		146	NU DV	ned		>4723	> 2	12/2	4/2009
	M.		V	completed cause of de	ath (Item 23a) (Type, PIIRDY STR		rr 101 - r.	ASTON. MD	21601	•

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

DEC 3 0 2003

parks

State of Maryland / Department of Health and Mental Hygiene 0 0 8

1 - For State Registrar Certificate of Death Rea. No. 2. Date of Death 1. Decedent's Name (First, Middle 3. Time of Death Month Day Year **Physician** 11:00 DM Laire Muldoon /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner Baltimore Washington Medical Olen Burnie Anne Arunde If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 M 2 3 F 88 009-09-6014 Director 16. 1920 Vermont Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, Ite Modical Exeminer must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ▼No Director Anne Arundel Gambrills MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2607 Chapel Lake Dr., Apt.#204 21054 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 □Yes 2 ☑No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: þ Specify. 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Emma Thomlette Euclide Gagnon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Deborah C. Roberts / daughter 1001 Agricopia Dr. La Plata, MD 20646 20b. Place of Disposition (Name of cemetary, crematory or other place MaryLand Veteran Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/31/2008 | Cheltenham, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Beall Funeral Home 6512 NW Crain Hwy. Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset,and Death and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): or Attending Physlcian: The law requires that the death certificate be executed Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 1 ☐Yes 2 ☐No 1 □Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 □ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Director: 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide within 24 hours a 🖆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 12ecember 22, 2008 00022463 eted cause of death (Item 23a) (Type, Print) A. Clen Burniu, Mb 2106 30. Name and address of person who 32. Registrar's Signature

State Registrar

Baltimore, Maryland 21215-0036

Box 68760.

P.0.

of Vital Records,

Division

DHMH 17 Rev 1/200

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** Anita M. Marcellino 2008 12:00P<sup>M</sup> 26 Dec. /Medical 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Heartlands Ellicott City Howard Year If Under 2 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Social Security Number **Funeral** Days Months 1 □ M 2 1 F 03-12-1921 MD 87 Director 215 12 4087 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f show dical Examiner must be notified at 1 ☐ Yes 2X No Director MD Howard Ellicott City 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3109 Hayfield Drive 21042 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ※ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Maryland 21215-0036 Specify 3 □ Widowed 4 □ Divorced White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I other than " Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any Injury or other traumatic event; 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anthony Dalfonzo Jenny unknown P 19a. Informant's Name/Relationship (Type. Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anne Marie Marcellino-Buehler 813 Caren Drive Eldersburg, MD 21784 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Crest Lawn Mem. Gard: 12-30-2008 Marriottsville, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee M01044 Shem Collins 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ATHERO SCLEROTIC Immediate Cause (Final CAPDIOVASCULAR **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to tor as a consequence of Examiner The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE: nse If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy for Month in the past 12 months?
1 Yes 2 No Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9☐Unknown 9 ☐ Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Mount Unknown Completed R-412 EDEMIA 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy perform certificate 2 No 1 Yes 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other:  $_{4\,\square\,\,\text{Nursing Home}}$  5  $\square\,\,\text{Residence}$  6  $ot\!\!\!/$  Other (Specify) asstd. lvg Hospital: 1 ☐ Yes 2 ☐ No Certification; To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Hospital or Attending 1 Natural 5 Pending investigation To the Hospital or Attenum within 24 hours after death.

To the Funeral Director: Af completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 X certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Dec. 29, 2008

EG

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

ROLLING ROAD

BAI TIMORE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1120

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 43364 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** O'Neil Griswold Murphy 22,2008 10:30 A M December /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Dorchester General Hospital Cambridge Dorchester 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) Days 1 € M 2 🗆 F Yre Director 217-28-3174 77 Nov 16,1931 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be northfud at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Dorchester Maryland Crocheron Funeral Director 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1488 Phillips Gunning Club Road 21627 US 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 □Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ 1 □Yes 2XXNo White Specify: 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Stationary Engineer State Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George W. Murphy Emily Pearl Todd ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rebecca Bradshaw Sister 517 Governors Avenue Cambridge, Maryland 21613 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 15 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dorchester Mem. Park 12/26/08 Cambridge, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Thomas Funeral Home, P.A Kin 700 Locust Street Cambridge, Maryland 21613 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) remorr hane **Physician** hour /Medical Due to (or as a consequent of): Examiner adrenal Metastatic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of): Division of Vital Records. P.O. Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 4 ☐ Pregnant at time of death 5 Other (specify) □Yes 2□No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☑ Xes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 01500se 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 □ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Mann of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 atural 5 Pending hours after death. uneral Director: A 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

(Check only

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Mame and address of person who completed cause of death (Item 23a) (Type, Print)



within 2

H0059973

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2008 1 - State Registral 43365 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 1048M MERICK ERWARD /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 3344-B Solomons Island Rd. Edgewater Anne Arundel If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Date of Birth (Month, Day, Year) 8/16/1930 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 ☑ M 2 ☐ F 577-38-9506 78 Director Washington, Usual Residence of Decedent filed within 72 hours after death with the Maryland I Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10b. County ir than "natural", or items 23a or 28a-f show the Medical Evantiner must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Anne Arundel Edgewater 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3344-B Solomons Island Rd. 21037 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married 1 ☐Yes 2 If Yes, Give altimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: \$ 3 Widowed 4 Divorced White Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) is marked other than College (1-4or 5+) 8th Painter Home Improvement permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harry W. Limerick Agnes Nallev 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lillian F. Limerick/ Wife 3344-B Solomons Island Rd., Edgewater, MD 21037 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12-20-08 Kalas Crematory Edgewater, MD 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signature of Fune al Ser 2973 Solomons Island Rd. Edgewater, MD 21037 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Ye ar 5 Other (specify) signed by the a d be detached f ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown has been si ye 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate ha irector, page 2 1 ☐ Yes 2 ☐ No 1 □Yes 2 □No Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 2 No 1 ☐ Yes 1 Inpatient 2 I ER/Outpatient 3 I DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation To the Hospital or Attendir within 24 hours after death.
To the Funeral Director: At completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) Chea who completed cause of death (Item 23a) (Type, Print) Name and address of person 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State 2 Registrar

Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene.  Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination must be notified at
	Physicia /Medica Examine
	LAdillille
Division of Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Funeral Director

		For State Registrar		State	of Mai	rylan	d / Depa <i>Ce</i>	artment of I <i>rtificate of</i>	lealth ar Death	nd Me	ntal Hy	/gien Reg. N		08	43366
Physicia /Medic		1. Decedent's Name Eduaro		rrama	Mani	vang					Date of December		<sup>1</sup> 8, 2	800	3. Time of Death 8:01 P M
Examin- Funeral		4a. Facility Name (h 21 Leath 5. Social Security N 213-37-8	erwood Ct	t.		(In yrs. I	ast birthday) Yrs.	4b. City, Town, or Burtons of Under 1 Year Months Days	7ille   If Under 24	Hrs. 8	Date of Bi (Month, D	irth	County of font go	omery 9. Birthp	lace (State or Foreign
	tor	Usual Residence of 10a. State		rv			, Town or Lo				•				0d. Inside City Limits 1 □Yes 2 🏋 No
23a or 28a ust be noti	ral Director	10e. Street and Nur		t.				10f. Zip Code 20866				Phi]	itizen of W	nes	
Department of Health and Mentar Hygene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examiner must be notified at once.	by Funeral	11. Marital Status 1	ed 2 <b>X</b> Married 4 □ Divorced	12. Was De Armed F 1 Tyes If Yes, 0 Year or	Forces? 3 2 📉 No Bive			Was Decedent of HIfYes, specify Cub		n? (Speci Puerto Ri	fy Yes or N can, etc.)	0-	Black	Asia	
iene. than "natui ne Medical	Completed	(Spec		ide completed	d) (1-4or 5+	)	(Give life.	dent's Usual Occu kind of work done DO NOT use retire er/Owner	during most of	f working			Kind of Bus		dustry
Mental Hyg arked other atic event, I	To Be C	17. Father's Name	(First, Middle, Last, Maniwang	)				•	18. Mother's			,		·)	
Health and em 27 is ma ther trauma	. 6	19a. Informant's Na Emir Man 20a. Method of Disi	iwang /	Type. Print) Son		20b. P	21 L	ng Address (Street eatherwoodsition (Name of	od Ct,		onsvi	.11e		0866	
artment of or ortant; If its injury or o		1 ☐ Burial 2 [	XCremation 3 ☐ 5 ☐ Other (Specif	(y)	n State	1	ropol	osition (Name of matory or other pla itan Cren 2. Name and Addre dvent Fur	natory	ecem 20	ber 2 008	4th	Alex	andr	ia VA
any per		23a. Part 1. Enter the shock, or hea	he disease, or com	plic fons that	t caused t	he death	F	alls Chu	rch VA	and_	Annap	olis		es, I	Approximate Interval Between
ysician Nedical aminer		Immediate Cause disease or condition resulting in death)		a. Due t	o (or as a	consequ	Dama Jence of):	ge Infarctio	nn.						Onset and Death
g physician and sthe burial-transit	edical Examiner	Sequentially list colliant, reading to line cause. Enter Unde Cause (Disease or that initiated events resulting in death) I	rlying injury	Due t	o (or as a	consequ	sence of):								
is been signed by the attending pheshould be detached for use as the	hysician/Med	IF FEMALE: 23b. Was deceden in the past 12 1 □Yes 2 [ 9 □ Unknown	months?		e birth 2 egnant at	. ☐ Fetal	Ideath 3	□ Ectopic pregnan □ Other (specify) _	су				23d. Date Mor		ery Day Year
en signed b	by P	Part II. Other signif	ficant conditions	contributing to	death but	not resu	ulting in the u	inderlying cause gi	ven in Part I.						ne cause of death?
ficate has be r, page 2 sh	Completed	05.14		1							per 1 □ Yes	opsy formed? 2 XN	d	Vere auto rior to cor eath? Yes	psy findings available mpletion of cause of 2 No
fter this certi neral directo	on: To Be	25. Was case refer examiner?  1  Yes 2 2  27. Manner of Deat 1  Natural	[No	28a. Da	☐ Inpatiente of Injury	,	ER/Outpatie	III 3 LI DOA		ing Home	e 5 X Res	sidence			(y)
arter death. Director: A I in by the fu	Certification:	2 Accident 3 Suicide 4 Homicide	investigatio 6	e 28e. Pla	ce of Injur Iding, etc.	y - At ho (Specif	ome, farm, st		]Yes 2□No		If. Location City or To			er or Rura	al Route Number,
within 24 hours arter death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 s	Medical Co	29a. Certifier (Check only one)	2 Medical Exa	miner: Onythe	the best of basis of anner stat	examina	wledge, dea	th occurred at the I	opinion, death	place, ar occurred	nd due to the	e, date a	nd place, a	ınd due to	the cause(s)
	Q	29b. Signature and	12 may	W	rdl	de	sk'u	DOC	se number 064615				ate signed 2/19/2		Day, Year)
D			e Wroble	wski MI	13	55 I	Piccar	d Dr. Roc	kville	MD	20850				
Sta Registr		31. Date filed (Mon	DEC 23 20	$008 \frac{32}{2}$	Registra	r's Signa	tur. A	arked							

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2008 Ernest Eugene Myers '00 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 511 Clyde Avenue omico 1ano If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Nov. 10, 1942 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) Months Days Hours 1 X M 2 □ F 66 212-40-7575 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1 X Yes 2 □ No Fruitland Maryland Wicomico 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21826 USA 511 Clyde Avenue 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ∐Yes 2 X No Specify: Snecify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry Residential and Elementary/Secondary (0-12) College (1-4or 5+) Owner/Operator Commerical Painting 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Disharoon John Myers 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 511 Clyde Avenue, Fruitland, MD 21826 Victoria A. Myers/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crematory of Delmarva 12/27/2008 Delmar, Delaware 22. Name and Address of Facility Zeller Funeral Home, P. O. Box 3171 1212 Old Ocean City Road, Salisbury, 21. Sign tupe of Funeral Service Life MD 21802 236. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, effock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final a disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate course. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 100 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 | Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 1 Natural 5 Pending investigation

Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Division of Vital Records, P.O. Box 68760 the signed by t I be detach this certificate

After t

after death Director:

24 hours a

within 2

Physician/Medical

9

Completed

Be

Certification: To

Medical

2 Accident

3 Suicide

29b. Signa

4 Homicide

Examine

**Physician** 

/Medical

Funeral Director

þ

Completed

Be

၉

Examiner

**Funeral** 

Director

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryla. Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-s show any injury or other traumatic event, the Wedford Evantine roust be notified at once.

Physician

/Medical

Examiner

Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Ite

Baltimore, Maryland 21215-0036

28c. Injury at Work?

1 ☐ Yes 2 ☐ No Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated

6 ☐ Could not be

ture and title of certifier

29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

79MU

State Registrar

			For State Registrar	State of Mar	-	epartment of F Certificate of I		Re	g. No. 2002	1,3368
	Physici /Medic		Decedent's Name (First, Middle, Last	Mary Elizab	eth Meyer	rs		2. Date of Death Month Decen	Day 29, 2008	3. Time-of peaks 0
	Examin			g Village Assiste			Location of Death Fros	stburg A		llegany
	Funeral Director		5. Social Security Number 212-38-5756  Usual Residence of Decedent	ex	in yrs. last birth	Months Days	Hours Min.	8. Date of Birth (Month, Day, November	Year) 9. Birth Cou	place (State or Foreign intry) Maryland
	aryland show	ž	10a. State 10b. County		0c. City, Town	or Location	Frostburg			10d. Inside City Limits 12 Yes 2 □ No
	ith the M or 28a-f	Director	10e. Street and Number	legany		10f. Zip Code		10	g. Citizen of What Cou	intry?
	ms 23a	Funeral	100 Vi	Ilage Parkway  12. Was Decedent Eve	er in U.S.	13. Was Decedent of H If Yes, specify Cuba	21532 lispanic Origin? (Sp	ecify Yes or No-	14. Race - Amer	
9800	72 hours after death with the Maryland "natural", or items 23a or 28a-f show often Examination mast be modified at	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 □ Yes 2 No If Yes, Give Year or Dates:		ff Yes, specify Cuba 1 □Yes 2 No	Specify:	Rican, etc.)	Black, White	White
21215-0036		Completed	15. Decedent's Ed (Specify only highest gra	de completed)	(	Decedent's Usual Occup Give kind of work done o life. DO NOT use retired	during most of work		6b. Kind of Business/I	
1212	filed within Hygiene. other than '		Elementary/Secondary (0-12) 12	College (1-4or 5+)			Teacher	e (First, Middle, M		chool
lanc	e d al	To Be	17. Father's Name (First, Middle, Last) Geo	orge Augustus M	leyers		To. Mother's Name		erine Douglas	
, Maryland	12 sho	ľ	19a. Informant's Name/Relationship ( Michael Meye		19b. I	Mailing Address <i>(Street</i> 21 Ke			City or Town, State, Zer, Maryland, 2	
Baltimore,	Pages nent of ant: If it ury or c		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif	Hemovai from State		Disposition (Name of crematory or other place lary's Catholic Co		2008		ng, Maryland
Balt	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licer  23a. Part 1. Enter the disease, or com	ham		1	8 East Mair	Street Lor	naconing, MD 2	zie Funeral Home 21539 Approximate
	Physician and Medical Examiner is the burial-transit	al Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.  Due to (or as a c	AL3A	umers	nta B:S	Se-se		Interval Between Onset and Death Onset and Death Onset and Death Onset and Death Onset and Onset
O. Box	attending for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of  1  Live birth 2  4  Pregnant at til 9  Unknown	☐ Fetal death	3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	у		23d. Date of deli	very Day Year
rds, P.	v requires that the dispension being the should be detached	δ	Part II. Other significant conditions of	ontributing to death but r	not resulting in t	the underlying cause giv	en in Part I.		acco use contribute to s 2 ☐ No 3 ☐ Pro	17
of Vital Records,		Completed	Carolio	mosky	005	teapore	3210	24a. Was an autopsy perform	prior to c ed? death?	topsy findings available ompletion of cause of
Vita	Physician: The this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	2 □ EB/Outr	patient 3 DOA Oth		h (Check only one	) nce 6  ☐Other <i>(Spec</i>	rifu)
ion of	or Attending Phy or death. Director After thi or by the funeral or	ation: T	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Y	28b. Ti	me of 28c. Injur		28d. Describe hov		ary)
Division		Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc.	- At home, farr (Specify)	n, street, factory, office		28f. Location (Str. City or Town,	eet and Number or Ru State)	ral Route Number,
	Hos Fur Fur	edical		ysician: To the best of on the basis of example and manner states	xamination and					
	To the within To the comple	Me	29b. Signature and title of certifier	S.L.Sano	dha	29c. Licens	e number	29	d. Date signed (Month	2008
		12	30. Name and address of person who			ype, Print)	17701		14 41	- 2008
	Sta	lØ	S.L. Sandhir 31. Date filed (Month, Day, Year)	M.D. 48 32. Registrar's		Terrace, F	Tostbu	ig. Mar	yland,	21532
	Registi		JAN - 6 20	09	A	Man Had				

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2 1 1 8 For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** King Cheuk 5:50 p<sup>M</sup> December 25, 2008 /Medical a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 1**X** M 2 □ F Months Days Hours Min. Director 063-54-4200 87 1921 China Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Maryland Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with ò items 23a 18805 Sparkling Water Drive, 20874 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after 1 ∐Yes 21⁄x If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 9 1 ☐ Yes 2 No Specify. Specify: þ Asian 3 Widowed 4 Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic average. Elementary/Secondary (0-12) College (1-4or 5+) Financial Management Accountant. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Unknown Mui Unknown 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kai H. Mui/Son 728 Prescott Court, Naperville, IL 60563 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Jan. 2, Gate of Heaven Cemetery 4 Donation 5 Dother (Specify) 2009 Silver Spring, Maryland 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Cardiac Arrhythmia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Myocardial Infarction Sequentially list conditions, if any leading to innecession cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed Acute Renal Failure and -tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f 1 ☐ Yes 2 ☐ No. o 9 Unknown 9 Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown should Anemia, Adult Failure to Thrive, Thrombocytopenia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 s autopsy page, r this certificate had ral director, page performed? 2 No 1 □ Yes 2  $\square$  No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ▼ No http://patient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After the 28a. Date of Injury (Month, Day, Year) 27 Manner of Death 28h Time of 28c. Injury at 28d. Describe how injury occurred Division 1X Natural 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No neral Director: filled in by the fi 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after 4 ☐ Homicide To the Hospital or within 24 hours aff To the Funeral Discompletely filled in 29a, Certifier \*\*Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D64478 December 26, 2008 3 rson who completed cause of death (Item 23a) (Type, Print)
Mehari, MD 9901 Medical Center Drive, Rockville, MD 20850 30. Name and address of Fisehatsion Mehari, MD

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

DEC

3 1 2008

Registrar's Signature

		for State Registrar	State of Ma		epartment Certificate				iene <sub>9. No.</sub> 2 N	0.8	L3370
Physic	ian	1. Decedent's Name (First, Middle, La	ast)					Date of Deat Month	Day	Year	3. Time of Death 4:25 DM
/Medi	cal	Constanc  4a. Facility Name (If not institution, gi	e Cousin Mcl	Mullin	4b. City, To	own, or Locat	ion of Death	December	29 4c. County	2008 of Death	4:25 рм
Exami	ner	Montgomery General			10.019,	01ne				ntgome	erv
Funeral		5. Social Security Number 6.		(In yrs. last birt	hday) If Under 1 Months I	Year If Ur Days Hou	nder 24 Hrs. urs Min.	8. Date of Birth (Month, Day,			lace (State or Foreign htry) ct of Columbia
Director		577-44-7064 Usual Residence of Decedent		70				octobel	17,1772	712(11)	or coldinora
ryland i <b>how</b>	_	10a. State 10b. County		10c. City, Town	or Location	·				10	0d. Inside City Limits
ne Ma 8a-f s	Director	Maryland Montgom	ery				lney				1 ☐ Yes 2 ☑ No
with the		10e. Street and Number	M - 4		10f. Zip C		2020	1	0g. Citizen of V		
ns 23	Funeral	18233 Rolling	12. Was Decedent E	ver in U.S.	13. Was Deceder		0832 c Origin? (Sp	ecify Yes or No-	14. Rac	U.S. e - Americ	
and 21215-0036  be filed within 72 hours after death with the Maryland ntal Hygiene.  d other than "natural", or items 23a or 28a-f show event, I = Marylen Ever it is must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1	0	If Yes, specify 1 ☐ Yes 2 2			Rican, etc.)		k, White, e	
5-0	eted	15. Decedent's E (Specify only highest gr	ducation rade completed)	16a.	Decedent's Usual ( (Give kind of work	Occupation done during	most of worki	na l	16b. Kind of Bu	siness/Ind	
2121; ed within 7 /giene. er than "r	Completed	Elementary/Secondary (0-12)	College (1-4or 5+		life. DO NOT use	retired) lerk			Dubliab	ina Ca	omn anu
Iryland 2121 should be filed within nd Mental Hygiene. marked other than imatic event, Irwin	ပိ	12 17. Father's Name (First, Middle, Las			6.		lother's Name	e (First, Middle, N	Publish Maiden Surnam		мрану
Maryland d 2 should be file th and Mental Hy ?7 is marked oth traumatic event	To Be	Arthur Cousin,	Sr.					Juanita De	ellinger		
0 8 8 8		19a. Informant's Name/Relationship	(Type. Print)	19b.	Mailing Address (S	Street and No	umber or Run	al Route Number,	City or Town,	State, Zip	Code)
		Janice Valois - D	aughter		44 Crystal		<del></del>				
Pages 1 Trent of Pant: If ite		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐		20b. Place of cemeters	Disposition (Name y, crematory or othe	of er place)	-	Date 2	20c. Location -	City or To	wn, State
Baltimore, permit. Pages 1 ar Department of Hea Important: If item; any Injury or other once.		4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Signature of Funer		Washingt	ton Nationa 22. Name and		The Thirt Committee of the Committee of	/02/2009	Su	itland	, Maryland
Dep Dep Bary Bary Bary Bary Bary Bary Bary Bary		Dame L	Lewon		Hines-Rir	naldi Fu	ıneral H	ome, Inc.	er Spring	. Mary	7land 20904
		23a. Part 1. Enter the disease, or con shock, or heart failure. List only	nplications that caused t	the death. Do n						,	Approximate Interval Between
Physician		Immedia e Cause (Final disease or condition	- ISCHE	_	COLINI						Onset and Death
Medical Examiner	П	resulting in death)	Due to (or as a	consequence o	of):						
	ĕ	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequence o	of):						
cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	C							7	
18760, Crate be executed physician and the burial-transit		resulting in death) Last	Due to (or as a	consequence o	f):						
587 ficate   physical	edical		d							-	
IVISION Of VITAI RECORDS, P.O. BOX 68760, C. 2. o.c. p.c., p. 3. 2. o.c. p.c., p. 2. o.c. p.c., p. 2. o.c. p.c., p. 2. o.c. p.c., p. 2. o.c. p.c. p.c. p.c. p.c. p.c. p.c. p.c	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 mopths? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome o 1  Live birth 2 4  Pregnant at 1 9  Unknown	☐ Fetal death	3 ☐ Ectopic pre 5 ☐ Other (spec				23d. Dat Mo	e of delive nth	ery Day Year
cords, P.O.	Š	Part II. Other significant conditions	contributing to death but	t not resulting in	the underlying cau	se given in P	art I.				e cause of death? ably 4 🖸 Unknown
as bee	Completed							24a. Was ar	24b. \	Vere autor	osy findings available
VITAL REC D C CAL Sician: The law certificate has ector, page 2 8	le le							autopsy perform 1 □ Yes 2	red?//	nor to con leath? □Yes	npletion of cause of 2 □ No
VITA VITA ician: Sertific	Be (	25. Was case referred to medical examiner?	Magnitali				lace of Death	(Check only one			
on of Vita of per in ding Physician: h. After this certific funeral director,	은	1 ☐ Yes 2 ☑ No 27. Manner of Death	Hospital: 1 ☑ Inpatien 28a. Date of Injury		patient 3 DOA			me 5 Reside			2
nding th. Afte e fune	ation	1 Natural 5 Pending 2 Accident investigation	(Month, Day,	Year) In	ijury M	o. Injury at Work? 1 ☐ Yes		Eod. Describe no	w mjary occum	eu	
To be Low Living to the Hospital or Attendi within 24 hours after death.  To the Funeral Director: A completely filled in by the fu	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined		ry - At home, fari (Specify)	m, street, factory, o	office		28f. Location (Str City or Town	eet and Numb State)	er or Rural	Route Number,
To the Hospital within 24 hours at To the Funeral D completely filled i	Medical (	29a. Certifier 1 Certifying P (Check only 2 Medical Exa	thysician: To the best of aminer: On the basis of and manner state	examination and	d/or investigation, ir	n my opinion.	death occurr	ed at the time, da	use(s) and mate and place, a	anner as st and due to	ated. the cause(s)
To the complex	Ň	29b. Signature and title of certifier			29c. L	icense numb	per .	29	d. Date signed	_	Day, Year)
4					1+	0007	100		12/30/0	18	
<b>-</b>		30. Name and address of person who	completed cause of dea	ath (Item 23a) (	Type, Print)	arri It	12tiaco	_			
Sta	ate	31. Date filed (Month, Day, Year)	Registrar	's Signature	29c. L 17 Type, Print)	261 1		<del>-</del>			
Regist		DEC 3 1 200	18 100000	S. A	marke						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month 4:45 PM Ruth Malinda Martin December 22,2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Mennonite Fellowship Home Hagerstown Washington If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 1 ☐ M 2 🖵 F 90 216-56-8455 Oct. 3, 1918 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Maryland | Frederick Mount Airy 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21771 703 North Warfield Drive USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: 3 X Widowed 4 Divorced White Year or Dates: 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 8 Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Samuel Diller <u>Maggie Martin</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Irvin S. Martin, Jr. 703 North Warfield Drive, Mount Airy, Maryland 21771 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Pine Grove Cemetery 12/27/2008 | Mount Airy, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Molesworth-William Funeral Home 21. Sanature of Duneral Service License 23a. Parti. Ent ir the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or eart failure. List only one cause on each line.

Immediate care (Final disease or condition resulting in death)

a. The total of the care of the condition resulting in death) 26401 Ridge Road, Damascus, Maryland 20872 Due to (or as a consequence of): Due to (or as a consequence of): Sequentially list conditions, i any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2200 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hoorsted 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

/Medical Examiner that the death certificate be executed o Records, law requires The Physician:

**Physician** 

/Medical

Examiner

Directo

Funeral

Completed by

Be ပ

Examiner

Physician/Medical

9

Completed

Be

Medical Certification: To

3 Suicide

29a. Certifier (Check only

Shahid

4 Homicide

29b. Signature and title of certifier

Shahid Mahmood
31. Date filed (Month, Day, Year)

DEC 2 9 2008

6 Could not be determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

580

32. Registrar's Signature

**Funeral** 

Director

s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.

Item 27 is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

Pages 1 and 2 should

permit. Pages 1 Department of H Important: If ite any Injury or ot

**Physician** 

burial-tran

as the for use

attending physician

the

à

funeral director, page 2 should

certificate has

After this

Director:

If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at

Vital Division or Attending.

filled in by within 24 hours at To the Funeral C

9

State Registrar

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Hagerstown

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Dav. Year)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Northern

			1 - For State Registrar	State of Maryland	d / Depa	artment of F rtificate of	lealth and M Death		ene J. No. 2 (	008	43	372
М	Physici	ian	Decedent's Name (First, Middle, Last)					2. Date of Death Month December	Day	Year	3. Time of	
É	/Medi	cal	4a. Facility Name (If not institution, give s	CLAY RALPH	MILLE		r Location of Death	December	27, 2 4c. County		3:00	A M
	Examir	ner	113 Easy Street #3	,		Thurm			ŕ	deric	k	
	Funeral		Social Security Number 6. Sex	7. Age (In yrs. la	ast birthday)	If Under 1 Year Months Days		8. Date of Birth		9. Birthpl	ace (State o	r Foreign
4,324	Director		101 30 3711 11	M 2□F 8	1 Yrs.	Wollins Days	Hours Will.	8. Date of Birth (Month, Day, ) June 19,	1927	Penn	sylvar	ıia
-	and t		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Lo	cation				10	0d. Inside Ci	ty Limits
	Mary Fishe	ţo	Maryland   Frederic	k Th	urmont						1. ☐Yes	2 □ No
	th the or 28a anotii	irec	10e. Street and Number			10f. Zip Code		100	g. Citizen of	What Count		
	ath will	la l	113 Easy Street #3	2		217				S.A.		
	filed within 72 hours after death with the Maryland Hyglene. ther than "natural", or items 23a or 28a-f show ther, the Medical Examiner must be notified at	Funeral Director	11. Marital Status  1 □ Never Married 2 Married	<ol> <li>Was Decedent Ever in U.S Armed Forces?</li> <li>1 ☐ Yes 2 No</li> </ol>	S. 13.	Was Decedent of H If Yes, specify Cub	lispanic Origin? (Spe an, Mexican, Puerto	cify Yes or No- Rican, etc.)		ce - America ck, White, e		
36	irs aft at', or xami	by F	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:		Specify	y: Wh	ite	
21215-0036	72 hou natura ical E	Completed	15. Decedent's Educ (Specify only highest grade	ation	16a. Dece	dent's Usual Occup	oation	10	Bb. Kind of B			
21	ithin 7 ne. nan "r	nple	Elementary/Secondary (0-12)	College (1-4or 5+)			during most of worki	'y				
	Hygiel Hygiel Ther th		8 17. Father's Name ( <i>First, Middle, Last</i> )		<u></u>	arn Pain	ting 18. Mother's Name	(First Middle M:		nting		
au	ould be f Mental H larked of	To Be	Henry Snyder Mille:	r			Edna Niss			,		
Maryland	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, the Me	F	19a. Informant's Name/Relationship (Typ	,			and Number or Rura	I Route Number,	City or Town,			
-	and 2		Sarah Miller / Wife				et #32, Tl	nurmont,	Mary1	and 2	1788	
Baltimore	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Important of Health and Mental Hygiene. Importants if item 27 is marked other than "hatural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Re	emoval from State 20b. Pl	ace of Dispo emetery, crei	sition (Name of natory or other plac	ce) 10/0		c. Location -	•	Ť	
ţ	permit. Pag Department Important: I' any injury o		4 □ Donation 5 □ Other (Specify)				tory 12/2		Smiths	-		and
Bal	Departing on the once.		21. Signature of Juneral Service Lic-use	Joshow Y	RÖ	BERT E	ss of Facility & S	SON, FUNER	RAL HO	MES, I	P.A.	
	* 表:		23a. Part1. Enter the disease, or complic shock, or heart failure. List only on	cations that caused the death	. Do not ent	or the mode of dying	AIN STREET ng, such as cardiac o	r respiratory arres	NT, MI	D 2178	Approximate	9
	Physician	X.	Immediate Cause (Final disease or condition	e cause on each line?		twetne	10 //	mary	)ice	nid	Onset and D	veen Jeath
	/Medical		resulting in death)	Due to (or as a consequ		, , , ,	10111	9	5,1	4	4~	7-1
	Examiner	L	Sequentially list conditions, b.		22-18-1							
	ted nsit	nine	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	- Due to (or as a consequ	eliče oij.							
<u>,</u>	ate be executed hysician and the burial-transit	Examiner	that initiated events c. resulting in death) Last	Due to (or as a consequ	ence of):							
190	ysicia re buri	cal	d									
89	rtifica ng ph		IF FEMALE:									
Вох	that the death certifica led by the attending ph detached for use as th	Physician/Med	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome pf pregnar 1☐Live birth 2☐Fetal	death 3□	Ectopic pregnancy	y			nte of deliver	-	/ear
	the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of de 9□Unknown	ath 5□	Other (specify) _			1410	,	Day 1	Gai
P.O.	The law requires that the tee bas been signed by the bage 2 should be detached.		Part II. Other significant conditions con	tributing to death but not resul	ting in the u	nderlying cause giv	en in Part I.	23e. Did toba	cco use cont	tribute to the	e cause of d	eath?
rds	w requires to been signer should be a	d by						1 ☐ Yes	2 □ No	3 Proba	ably 🛝	Jnknown
Records,	aw requis been 2 should	Completed						24a. Was an	24b.	Were autop	sy findings a	available
	The lav ate has page 2 s	mo						autopsy performe 1 Yes 2	ed?	death?	npletion of ca 2□ No	luse of
/ita	ysician: The lis certificate hadirector, page	Be	25. Was case referred to medical examiner?				26. Place of Death	-1-				
or Vital	Physician: this certific	은	1 ☐ Yes 2 No	ospital: 1 ☐ Inpatient 2 ☐ E	R/Outpatien		4 LI Nursing Hor	ne 5 Residen			)	
on	ing After une	tion:	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	Wor	yat k? Yes 2 ∐No	28d. Describe how	injury occur	rea		
Division	Attending r death. ector: After by the fune	fica	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At hor	ne, farm, str			28f. Location (Stre		er or Rural	Route Num	ber,
õ	s after	Certification:	4   Hornicide	building, etc. (Specify)	,			City or Town,	State)			
	Hospit Hour Tuneri		(Check only 2 Medical Examin	ician: To the best of my know er: On the basis of examinati	/ledge, deatl	occurred at the til	me, date and place, a	and due to the cau	se(s) and ma	anner as sta	ated.	)
	To the Hospital or Attend within 24 hours after death. To the Funeral Director: /	Medical	one)  29b. Signature and title of certifier	and manner stated.		29c. Licens						
	Mil Wil		2.5b. Signature and title of certifier	6.			31058	290	I. Date signe	29-	,	
			30. Name and address of person who con	mpleted cause of death (Item	23a) (Type						-	
			Gene F. Ashe	10200 CC	pper	mine F	Rol Woo	odsboro	, MD	21	198	
	Sta	ate	31. Date filed (Month, Day, Year)	3 Registrar's Signat		alle)	· · · · · · · · · · · · · · · · · · ·				<del></del>	

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Day lorman E. Miller, Jr. 2008 2300 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Numbe 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 2-8-1927 Birthplace (State or Foreign Country) **Funeral** Year) 1, M 2 □ F Months Days Hours Min. 81 Yrs Director 578-26-9719 Washington DC Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Modical Explainer must be notified at 10d. Inside City Limits Director 1 Tyres 2 □ No Maryland Anne Arundel **Annapolis** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2539 Painter Ct. 21401 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any Injury or other traumatic event, the Medical Execution 1 Styes 2 No
If Yes, Give 40-44
Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 □Yes 2 No Specify: þ Specify: White 3 AWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 News Paper Printer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Norman E. Miller, Sr. ပ Mary E. Wright 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert E. Miller / Son Crofton, Md. 21114 1825 Judicial Way 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cem. 12/19/2008 Silver Spring, Md 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Funeral Service Licensee MO0544 16000 Annapolis Rd. Bowie, Maryland 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 1 cute aille Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physlclan: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) P.O. cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2 X No 1 □Yes 1 ☐ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2√No Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death After t 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 2 Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No after death Director: completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital of within 24 hours at To the Funeral D 29a. Certifier Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and magner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 12-15-2008 30. Name in address of person who completed cause of death (Item 23a) (Type, Print) Parkway Amapolis, md Jae Medical 001 . Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 008 1 - For State Registrar 43374 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Wilbur Wayne Newcomb /Medical December 18 2008 7:15 p. 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Laurel Regional Hospital Laurel Prince George's 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sev 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1X M 2 F 219-56-8768 56 Yrs Director June 25, 1952 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits ed other than "natural", or items 23a or 28a-f shevent, the Wedical Examination ast be notified Director MD Montgomery Burtonsville 1 ☐ Yes 2 No the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with tonent of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural", or items 23a or items. 3805 Ski Lodge Drive Funeral 20866 USA Baltimore, Maryland 21215-0036 \ ↓ 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 1 Never Married 2 Married If Yes, Give Year or Dates þ 1 ☐ Yes 2X No Specify Specify: 3 ☐ Widowed 4X Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) scientist government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Russell Newcomb Martha McGlaughlin 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gary Newcomb brother P. O. Box 135, Church Creek, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of F
Important: If ite
any Injury or ot 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory 12/19/08 Salisbury, MD Signature of Faneral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. in long 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) end stage gastric cancer with metastasis /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Diserto for es a nonsequence off death certificate be executed the burial-tran Due to (or as a consequence of) Box 68760. physician Physician/Medical as b attending IF FEMALE: use If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year signed by the a I be detached fo 5 Other (specify) o. ☐Yes 2☐No the 9 Unknown by ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performed? Yes 2 2 No page certificate 1 □ Yes 1 ☐ Yes 2 ☐ No Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1K Yes 2 □ No 1 🖾 npatient After this Certification: To 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 Pending investigation 1X Natural within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) D64874 12/18/08

State Registrar Shahab Bayani,

10724 Little Patuxent Pkwy. Suite 200, Columbia, MD 21044

person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

M.D.

Baltimore, Maryland 21215-0036

requires that the death certificate be executed Division or Vital Records, P.O. Box 68760 page funeral director

1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 28 DECEMBER 10:05AM<sup>M</sup> MILFORD A. ORNDORFF 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner HOSPICE OF QUEEN ANNE'S **OUEEN ANNE'S** CENTREVILLE If Under 1 Year | If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number Days 1 X M 2 □ F Months Hours WEST VIRGINIA 81 579-30-0622 APRIL 9, 1927 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 X No Director QUEEN ANNE'S GRASONVILLE MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 906 CHESTER RIVER DRIVE 21638 UNITED STATES by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1945–1951 1 ☐ Never Married 2 Married 1 ☐ Yes 2 X No Specify Specify: WHITE 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 OWNER RETAIL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HARRY C. ORNDORFF ELSIE SCHAEFFER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 is any injury or other tray once. 906 CHESTER RIVER DRIVE, GRASONVILLE, MARYLAND 21638 PATRICIA ORNDORFF/WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State JANUARY 2 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State CHESAPEAKE CREMATION 2009 STEVENSVILLE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, P.A.
106 SHAMROCK ROAD, CHESTER, MARYLAND 21619 23a. Part1. Enter the disease, or complications to a shock, or heart failure. List only one cause on caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. Approximate Interval Between Onset and Death lateral Immediate Cause (Final Trephile ears disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Denesta. 1□ Yes 2**X** No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ 2 ER/Outpatient 3 DOA HOSPICE 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After 1 Natural Injury 5 Pending after death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Russell a Selin 44258 12-29-2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Scholles of 5 Easton und 21601 RUSSELL A 555 Cynwood State Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2 0 8 2. Date of Death 1. Decedent's Name (First, Middle, Last) UET 1202 M 2 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death ANNE ARUNDEL MANDRIN CHESAPEAKE HOSPICE HOUSE HARWOOD 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Days Hours Min. 1 M 2 F Months FEBRUARY 8-1937 MINNESOT A 71 474-40-8079 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 X No CROWNSVILLE MARYLAND ANNE ARUNDEL 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21032 UNITED STATES 66 SUMMERHILL MOBILE PARK 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? 1 ☐ Yes 2 X No 1 ☐Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2**X** No Specify Specify: WHITE 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 SECRETARY **AEROSPACE** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) MATH PERNE TERESIA SRNA 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) GRAHAM RUSH GOLD/STEP-SON 3411 ROSALIE AVENUE, BALTIMORE, MARYLAND 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition DECEMBER 26 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 2008 ANNAPOLIS, MARYLAND BESTGATE MEMORIAL PARK 4 ☐ Donation 5 ☐ Other (Specify) MO0672 ROAD, ANNAPOLIS, MARYLAND 21401 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Ye ar Pregnant at time of death 5 Other (specify) 1 ☐ Yes 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐Yes 2 ☐ No 24a. Was an autopsy 1 ☐ Yes 26. Place of Death (Check only one, Hospital Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ACCE 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred HOUSE

**Physician** /Medical Examiner Hospital or Attending Physiclan: The law requires that the death certificate be executed

Physician

/Medical

**Examiner** 

**Funeral** 

Director

28a-f show

ŏ

23a

items ;

ō

"natural"

than

nt of Health and Mental Hygiene, If item 27 is marked other than or other traumatic event, the M

permit. Pages 1
Department of H
Important: If itel
any injury or ott
once.

the Medical Exacitment ust be notified at

Director

Funeral

by

Completed

Be

မ

the Maryland

Pages 1 and 2 should be filed within 72 hours after death with

Baltimore, Maryland 21215-0036

Examine Physician/Medical δ Completed Be

attending physician and for use as the burial-trar been signed by the should be detached s certificate has birector, page 2 s n 24 hours after death.

e Funeral Director: After this certific letely filled in by the funeral director, Medical Certification: To

Division of Vital Records, P.O. Box 68760,

25. Was case referred to medical examiner?

1 Natural 2 ☐ Accident 5 ☐ Pending investigation 6 ☐ Could not be 3 Suicide determined 4 Homicide

28a. Date of Injury (Month, Day, Year)

1 ☐ Yes 2 ☐ No Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

ame and address of person (CHAEL

29b. Signature and title of certified

31. Date filed (Month, Day, Year)

29a. Certifier

who completed cause of death (Item 234) (Type, Print)

and manner

DEFENSE HOHWAY

29th Date signed (Month, Day, Year)

State Registrar

32. Redistrar's Signature DEC 2 9 2008

park

within 24 hound to the second to the second

the

amend line 2 per me aaco hlth dept 12/31/08 dlw All Copies Are Legible.
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-09651 State of Maryland / Department of Health and Mental Hygiene Vito Pugliese Certificate of Death Reg. No 1- For State 2. Date of Death 12/23 Registrar . Decedent's Name (First, Middle,Last) Month 0905 hrs Physician/ 2008 Vito William Pugliese December 22 Medical Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Anne Arundel Annapolis Anne Arundel Medical Center 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 6. Sex oreign New York 5. Social Security Number Funeral Days Hours Months Aug. 27, 130-22-9708 Director Yrs 1 XXM 2 F 77 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 XXes 2 No Annapolis Anne Arundel Maryland s 23a or 28a-f show notified at once. Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho
injury or other traumatic event, the Medical Examiner must be notified at once. 10g. Citizen of What Country? Director 10f, Zip Code 10e. Street and Number United States 21401 710 Americana Drive Apt 27 Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. Funeral 11. Marital Status White, etc. Armed Forces? 1 Never Married 2 Married 1 X Y Yes 2 No If Yes, Give Year 1952 - 1952 Specify: White Yes 2 XX No specify: 3 Widowed 4XX Divorced 16b. Kind of Business/Industry ģ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) 5+ Elementary/Secondary (0-12) State of Maryland Attorney 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last)
Tommaso Pugliese Teodolinda Bottazzi 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) 225 Starr Street, 2D Brooklyn, NY 11237 Linda R. Pugliese / Daughter 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 1XX Burial 2 Cremation 3 Removal from State crematory or other place)
Charles Cemetery 12/29/2008 Middle Village, NY Donation 5 Other Specify 22. Name and Address of Facility John M. Taylor Funeral Home, Inc 21. Signature of Funeral Service Licensee 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and **Physician** failure. List only one cause on each line. Death a. Atherosclerotic Cardiovascular Disease **Medical** Immediate Cause (Final disease √aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine ause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit Physician/Medical AMENDED UNPENDED 23d. Date of delivery Division of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE: Day Year 3 Ectopic pregnancy Month 23b. Was decedent pregnant in the Fetal death Live birth 2 past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 ✔ Unknown ≥ 24b. Were autopsy findings available Completed 24a Was an prior to completion of cause of autopsy performed? death? 1 2 No Yes 2 ✔ No 26.Place of Death (Check only one) 25. Was case referred to medical Be Other<sub>4</sub> Other: Nursing Home 5 Residence 6 Hospital: 1 examiner? DOA Inpatient 2 V ER/Outpatient 3 No 1 V Yes 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 27. Manner of Death Certification Yes 2 No 1 V Natural Pending 28f. Location (Street and Number or Rural Route Number, City Investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc or Town, State) Could not be 3 Suicide (Specify) Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b Signature and title of certifier December 23, 2008 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Patricia Aronica-Pollak MD. Assistant Medical Examiner 32. Registrar's Signature 31. Date filed (Month, Day, Year) State **DEC 29** Registrar ORIGINAL

DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician 1:43 RM Marca 08 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore None If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Bay, Year) 42 9. Birthplace (State or Foreign **Funeral** Days 1**X** M 2□ F Maryland 216-42-1645 66 Yrs. Director Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. Maryland Anne Arundel Annapolis 1X Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21403 USA 235 B Boxwood Rd. Apt 206 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 XYes 2 No If Yes, Give Year or Dates 1968-69 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 □ Yes 2X No Specify: Specify: Black <u>ک</u> 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th College (1-4or 5+) Laborer Welder Machinist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lenoise Day Clarence I. Pack ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2140319a. Informant's Name/Relationship (Type. Print) 235 B Boxwood Rd. Apt 206 Annapolis, Md. Zeldia Peters(Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 12-29-08 Crownsville, Md. Maryland Veteran 4 ☐ Donation 5 ☐ Other (Specify) Miniame Reactise of Socility Sons Mortuary, P.A. 21. Signature of Funeral Service Licensee 821 West St. Annapolis, Md. 21401 ary Si Ressell 66/83 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** erebra LLU KUEWN /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner nding physician and use as the burial-trans Due to (or as a consequence of): Box 68760. Physician: The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year 5 ☐ Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ 1 Yes 2 No 3 Probably 4 Unknown Atter this certificate has been s funeral director, page 2 should i Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1 ☐ Yes 1 TYes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 🗹 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 27. Manger of Death Time of 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 □Yes 2 □No death. investigation 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one)

State Registrar 29b. Signature and title of certifier

John S. Lake M. D. 3900 L

Year

2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Raven Boulevard

29c. License number

34359(OHIO)

Baltimore, Maryland 2/2/8

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year & **Physician** 0615 M 12 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mandrin Chesapeake Hospice House Anne Arundel Harwood If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 □ M 2 🗹 F 134-14-5681 84 Director 6/10/1924 <u>Pennsylvania</u> Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar mine. 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Funeral Director Maryland Anne Arundel Riva 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 528 Poplar Drive 21140 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □ Yes 2 ¼ No Specify: Completed by 3 X Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Professor of Art College Professor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Kachuck Lydia Greenberg ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Pittard/ Son 528 Poplar Drive, Riva, Maryland 21140 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Kalas Crematory 12/22/08 Edgewater, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Funeral Pervice Licenses 22. Name and Address of Facility George P. Kalas Funeral Home Must villate 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Onset and Death Immediate Cause (Final disease or condition resulting in death) on chrome **Physician** AILURE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of as the burial-tra Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 Ø No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 LLOUS 601 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an 1□ Yes 2□ No 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence & Other (Specify) Hospital: 1 Yes 2 No HUSPILE Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred HULSI 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No n 24 hours after death. ne Funeral Director; A oletely filled in by the fu 2 Accident

Hospital or Attending Physician; The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

and

þ

certificate

this

After t

within 2

2

3 Suicide 4 Homicide

29b. Signature and title of dertifier

29a. Certifier

(Check only one)

6 Could not be

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

o completed cause of death (Item 23a) (Type, Print) 30. Name and address of person w W

and manner stated.

29d Date signed (Month, Day, Year)

State

Medical

23 31. Date filed (Month

32. Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Yvonne Parker 1:30 p. December 24 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Peninsula Regional Medical Center Salisbury Wicomico Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Davs Hours 1 M 2 T F 72 Director 228-44-8180 Oct. 5, 1936 New Jersev Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County r 28a-f show notified at MD Worcester Snow Hill 1X Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? o e items 23a cliner must be 430 W. Market St. 21863 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status unk 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 【★No If Yes, Give Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2X No black Specify. \$ 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unknown unknown unknown is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be unknown unknown ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cheryl Senkbeil 1504 Riverside Drive, Salisbury, MD item 27 i p.r. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages
Department of I
Important: If it
any Injury or o
once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/26/08 Salisbury Crematory Salisbury, MD 22. Name and Address of Facility Thomas Funeral Home P.A. 21. Signature of Funeral Service Licensee thus lower 700 Locust St., Cambridge, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final CEREBROVASCULAR ACCIDENT WITH DYSPHAGIA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner AZENCIMEN' DEMENTIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the attending p 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy Month in the past 12 months? Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy Hospital or Attending Physician; 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 3[10 DOA 1 Inpatient 2 ER/Outpatient Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t 1 Natural 5 Pending investigation Injury Notice within 24 hours after acc...

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only

State Registrar one)

29b. Signature and title of certifier

31. Date filed (Month, Day,

29c. License number

10062172

1604 MARKET STREET POLOMOKE CITY MD 21851

29d. Date signed (Month, Day, Year) 12/24/2008

and manner stated.

32. Registrar's Signature

MI)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHARAD & SATYAL, MD 16004 MAR

JATYAL, MD

State of Maryland / Department of Health and Mental Hygien ) 1 9 43381 Amended, #10e, 1- State Registrar TCHD, 01/05/2009, TLS Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Virginia Liston Parkerson 12 24 2008 7:30a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Talbot Hospice House Easton Talbot 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

8. 5. Yrs. Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□M 2ਊF 85 Yrs. Director 429-36-3464 11-01-1923 Arkansas Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r then "naturel", or iteme 23s or 28s-f ehow the Medical Examiner must be notified at Md XXYes 2□No Talbot St. Michaels Directo 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? <del>Chestinu</del>t 219 E. Street 21663 USA Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry event. the Me Elementary/Secondary (0-12) College (1-4or 5+) Industry 12 years Secretary permit. Pages 1 and 2 should be file Department of Heath and Mental Hy important: If item 27 is marked othery injury or other traumatic event 9068. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be H.P. Liston Lilly Clyde Stacey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Parkerson (son) P. O. Box 1062 St. Michaels, Md. 21663 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 

Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Spring Hill 12-30-2008 Easton, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility R. Carroll Hurley Funeral Home, PC P.O. Box 518, St. Michaels, Md. 21663 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** LUNG Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician; The law requires that the death certificate be executed ettending physicien end for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Yes 2□No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performer Yes 2 this certificate h 1□ Yes ours after death.

neral Director; After this certificatile in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ۵ 28a. Date of Injury (Month, Day Year) 27. Manner of Death Natural 2 Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending 1 Yes 2 No investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral D 29a. Certifier 🔁 Certifying Physician: To the best of my knowled 🤌 death occurred at the time, date and place, and due to the cause s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D6670 TLS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Halverson MD TEN DR SULE 302 8821 2. Registrar's Signature 31. Date filed <sup>ar)</sup>2008 State Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Date of Death Month 1. Decedent's Name (First, Middle, Last) Day **Physician** Vera Parks DECEMBER 19, 2008 9:00AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Reeders Memorial Home Boonsboro Washington If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 1 □ M 2 🛚 F Yrs 81 02/16/1927 Director 220-30-5118 ShadySide, MD Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits MD Washington Boonsboro 1 X Yes 2 □ No Director 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or must be r 141 Main Street USA 21713 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. injury or other traumatic event, the Medical Examiner 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 1 XNever Married 2 Married 5 1 ☐ Yes 2X No White þ Specify 3 Widowed 4 Divorced 'natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 03 Housekeeper Home Care 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Parks JR. Minnie Louise Atwell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health ar Important; If item 27 is William Parks Brother 130 Chantilly Hagerstown, MD 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Atlantic Crematory 12/22/08 Glen Burnie MD 4 ☐ Donation 5 ☐ Other (Specify) 21401 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Hardesty Funeral Home P.A. 12 Ridgely Ave Ann, MD Jak 23a. Part1. Enter the isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death 0 - 30 mm Immediate Cause (Final disease or condition resulting in death) **Physician** A CON ONO /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to o as a consequence of) Examine The law requires that the death certificate be executed avel Due to (or as a consequence of) physician a the burial-1 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔊 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? page 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one)

Division or Vital Records, P.O. Box 68760. Hospital or Attending Physician: Director; / within 24 hours at To the Funeral Completely filled it

Name, Facks, Vt Baltimore, Maryland 21215-0036

P Certification: Medical

29b. Signature and title of certifier

Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔭 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

29c. License number

D46561

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DR. GHAZALA QADIR 20311 LAPPANS ROAD, BOONSBORO, MARYLAND 21713/

301-432-8470

29q. Date signed (Month, Day, Year)

31. Date filed (M 2. Registrar's Sign ture

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death December 22 **Physician** 2008 Harvey Pinkney 0730 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Genesis Elder Care @ Spa Creek Annapolis Anne Arundel | Trunder 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. | May 26 194 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral 1 X M 2 □ F 60 Yrs. 1948 Maryland Director 214-56-0601 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director Maryland Anne Arundel 1XYes 2 □ No Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 29 West Washington St. Apt 404 21401 USA permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If frem 27 is marked other than "nature!" any injury or other traumatic exercises. Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Forces? 1 Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify: Specify: Black ş 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Anne Arundel Co. Elementary/Secondary (0-12) College (1-4or 5+) 12th Custodian Public Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harvey Pinkney Phyllis Ann Gross 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Aldena L. Leggett(Cousin) 3436 Cohasset Ave Annapolis, Md. 21403 20b. Mace of Displayorn (Name M. 20a. Method of Disposition 20c. Location - City or Town, State Date 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Church Cemetery | 12-27-08 Lothian, Md. 4 Donation 5 Other (Specify) himame Receise of & cilisons Mortuary, P.A. 21. Signature of Funeral Service Licensee 821 West St. Annapolis, Md. 21401 B. Teese 11100483 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Vears disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any, reading to include cause. Enter Underlying Cause (Disease or injury that initiated events Day to (or as a nonsequency of): Examiner resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death

1 Natural

2 Accident 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical

O. Box 68760. The law requires that the death certificate attending p certificate has been signed by the rector, page 2 should be detached ۵ of Vital Records, Attending Physician: To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Division

physician and the burial-transit

pe

28a-f show

with

7 is marked other than "natural", or Items 23a or 28a-f sho traumatic event, "ne Medical Evan, "ner must be mailined at

29b. Signature and

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ercz

Defense they 2225

31. Date filed (Month, Day Registrar

(Check only one)

avI

Registrar's Signatu

and manner stated.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death December 15 2008 **Physician** Bernard Parker /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 855 Spa Rd. Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day OCt 10 5. Social Security Number 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign Funeral <sup>Year)</sup>922 Months Days Hours Maryland 11√2 M 2 □ F 215-12-8650 86 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm, Medical Evanding and other traumatic event, I'm, Medical Evanding and Director Maryland Anne Arundel 1X Yes 2 □ No Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 855 Spa Rd. 21401 USA Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian. Was Decedent Ever in o... Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: W.W. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 □Yes 2**X** No Specify: Specify: Black ģ 3 Widowed 4 □ Divorced II Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) S Naval Research Elementary/Secondary (0-12) College (1-4or 5+) 12th 2yrs Electronic Technician Development 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be James Parker Katie McGowan ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald B. Parker(Son) 6428 Riverhill Dr. Flowery Branch, Ga. 30542 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 12-19-08 Metro Crematory Baltimore, Md. 4 Donation 5 Dother (Specify) Miniame Rease of Scill Sons Mortuary, P.A. 21. Signature of Funeral Service Licensee Farry 821 West St. Annapolis, Md. Diffeese Moorg 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Trterioscleratio disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). that the death certificate be executed and burial-trar Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) signed by the a P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has page 2 autopsy performed certificate 1 ☐ Yes 2 ☐ No 1 □Yes 2 □ Mo 25. Was case referred to medical funeral director Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 XYes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 5 Pending n 24 hours after death.

■ Funeral Director: A pletely filled in by the fu death. 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier DEPUTY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ones , mD 31. Date filed (Month, Day, Year) 32. Registrar's Signature 2008 19 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 1 - For State Registra 43385 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Day **DECEMBER 23, 2008** 10:33 P M RICHARD RONALD RITZMANN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ANNE ARUNDEL ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. JUNE 1 Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Country NEW YORK 1**X** M 2□ F Months 75 118-24-3331 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show nust be notified at 1 ☐ Yes 2X No Director ANNE ARUNDEL **EDGEWATER** MARYLAND 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 23a or 2 21037 UNITED STATES 87 STEWART DRIVE, #313 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 14. Bace - American Indian. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after d
Department of Health and Mental Hygiene.
Important: If item 27 Is marked other than "natural", or iten
any Injury or other traumatic event, In Medical Ever. Inc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed by Specify: WHITE 3 Widowed 4 Divorced 1964 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) REAL ESTATE College (1-4or 5+) Elementary/Secondary (0-12) SELF-EMPLOYED DEVELOPMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be RICHARD RITZMANN HELEN WALTEN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 07645 MARYALICE K. RITZMANN/WIFE 138 NORTH KINDERKAMACK ROAD, UNIT B, MONTVALE, NJ 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State CHESAPEAKE CREMATION DECEMBER 27, CENTER 2008 STEVENSVILLE, MARYLAND 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility FELLOWS, HELFENBEIN AND NEWNAM CREMATION AND FUNERAL CARE, P.A., 814 BESTGATE ROAD, ANNAPOLIS, MARYLAND 21401 21. Signature of Funeral Service Licer Well Exporus 7M00672 23a. Part 1. Enter the disease, or complications that caused the death. Shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): attending physician for use as the hurial Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) P.0. nis certificate has been signed by the a director, page 2 should be detached f 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Ś 4 [[] Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2 1 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1/☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To in by the funeral 28b. Time of 27. Mariner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred After √ □ Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a completely filled 29a, Certifier 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1.54 Year) **2** 31. Date filed (Month, 32. Registrar's Signature State 9 Registrar

DHMH 17 Rev 1/2001

For	State of M	ai yiai i	u / De	partifien	II OI II	eailii ai	IU IVI	ептаг пу	giene	2 0	በጸ	433	RF
State Registrar			C	ertificat	e of E	Death			Reg. No.	20	00	700	
1. Decedent's Name (First, Middle, Last	1)							2. Date of De			Vass	3. Time of D	eath
Genevieve Kathl	een Rohr							Deceml	oer 2		Year 2008	8:40	$P^{M}$
4a. Facility Name (If not institution, give	street and number,			4b. City,	Town, or	Location of	Death			County	of Death		
Heritage Harbour	Health Co	nter			Annaı	polis			ł	Ann	e Aru	ndel	
5. Social Security Number 6. Se	7. A	ge (In yrs.	last birthd	y) If Under	1 Year	If Under 24		8. Date of Bit	th Year		9. Birthp	lace (State or	Foreig
281-14-2044	⊐м 2∭Т F	85	Yrs	Months	Days	Hours	Min.	2/17/	1923		Coun Oh i	Lo	
Usual Residence of Decedent				<u> </u>									
10a. State 10b. County		10c. Cit	y, Town or	Location							10	0d. Inside City	
Pennsylvania Fay	ette	Uı	niont	own								1 ☐ Yes 2	≥ XNc
10e. Street and Number		•		10f. Zip	Code				10g. Cit	izen of V	Vhat Coun	try?	
104 Concord Place				1.	5401					USA			
11. Marital Status	12. Was Decedent	Ever in U.	S. 1	3. Was Deced	dent of His	spanic Origi	n? (Spe	cify Yes or No	)-		e - Americ		
1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 📉	No		1 ☐ Yes		n, Mexican, I	ruerto r	nicari, etc.)			k, White, e	etc.	
3 M Widowed 4 □ Divorced	If Yes, Give Year or Dates:			I L Yes	ZALINO	Specify:				Specify	': Wh	nite	
15. Decedent's Edu			16a. De	cedent's Usua ive kind of wo	al Occupa	ition	of summerim		16b. Ki	nd of Bu	usiness/Ind	lustry	
(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or	5+)	lif	e. DO NOT us	se retired)	uring most o	ii WOIKIII	y					
12th	5-(		H	omemak	er					Hom	e		
7. Father's Name (First, Middle, Last)						18. Mother's	s Name	(First, Middle	, Maiden	Surnam	ne)		
Sylvester Hu	mmel					Не	len	Krebs					
19a. Informant's Name/Relationship (T	ype. Print)		19b. M	ailing Address	(Street a	nd Number	or Rura	l Route Numb	er, City o	r Town,	State, Zip	Code)	
Nikki L. Tinsley/	Parsonal	Ran	12	30 Cru	mmo11	l Avo	۸,	nanoli	i a N	an a	1403		
20a. Method of Disposition	1 CI SOMAI	20b. F	lace of Di	sposition (Nar	ne of	i		ate			City or To	wn, State	
1 Burial 2 Cremation 3 1		6		rematory or o is Crem			12/2	6/08	Ed	o Aus	iter,	MD	
4 ☐ Donation 5 ☐ Other (Specify,			Kare			-	•	·		_		al Home	
21. Signature of educati service Licens	see												
In auce									-	wall	er, M	D 2103	′
23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or			n. Do not	enter the mod	de of dying	g, such as ca	ardiac o	r respiratory a	rrest,			Approximate Interval Betwee Onset and De	
Immediate Cause (Final disease or condition	SEPSI	5									F	Onset and De	rati i
resulting in death)	Due to (or as	a conseq	uence of):										
	CHOL	ECYS	TIS	, AC	LITH	9							
Sequentially list conditions, f any, leading to immediate cause. Enter Underlying	Due to (or as	a conseq	uence of):										
Cause (Disease or injury that initiated events	. LEUR	(OC)	TOS	IS.									
resulting in death) Last	Due to (or as			-									
	DEME	INT	IA										
	u		•										
IF FEMALE:	23c. If yes, outcome	of preana	incy							334 D-1	to of dollars	71.6	
in the past 12 months?	1 Live birth	2 Feta	l death	3 Ectopic p							te of delive nth	ry Day Ye	ar
1 ☐ Yes 2 ☑ No	4 ☐ Pregnant a	it tille of c	eatti	5 ☐ Other (sp	Jecny)								

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the "Medical Evantines" out to multilled at once.

Baltimore, Maryland 21215-0036

Director

Be Completed by Funeral

၉

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-tran.

Division of Vital Records, P.O. Box 68760,

IF F	EMALE:
23b.	Was decedent pregnant
	in the past 12 months?
	1 ☐ Yes 2 Mo
	9 Unknown

Part II. Other significant conditions co	ontributing to death but not resulting	ng in the underlying cause	given in Part

1 ☐ Yes 2 ☐	]No 3∏Pr	robably 4 🔀 Unknov
24a. Was an autopsy performed? 1 □ Yes 2 ☒ No	death?	utopsy findings availab completion of cause o

25. Was case referred to medical examiner?	_				
1 ☐ Yes 2 🙀 No	Ho	spital:	1 Inpatient	2 ER/Outpatient	3[
27 Manner of Death			Date of Injury	28h Time of	

6. Place of Death (Check only one)								
4 Nursing Ho	me	5 Residence	6 ☐Other (Specify)					
	204	Deparibe how init	in consumed					

1 ☐ Yes 2 ☐ N	lo	н
27. Manner of Death		
1 🔀 Natural	5 Pending investigation	
2 Accident	investigation	1
3 Suicide	6 Could not be	е
4 Homicide	determined	

riospila	1 ☐ inpatient	2 🗆	ER/Outpatient	3 □	DOA
288	Date of Injury (Month, Day, Ye	ear)	28b. Time of Injury	М	280

	28c. Injury at Work?		
VI	1 □Yes	2 No	

Other:

28d.	Describe how injury occurred	

29a. Certifier	
(Check only	
one)	

and manner stated.

determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)								
1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.    Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)										

29b.	Sigr	ature	and	title	of	certifie
		F	K	3	li-	NA.

Bai Kanu, M.D.

29c. License number D0058580 29d. Date signed (Month, Day, Year) 2008

State Registrar

within 24 hours after death.

To the Funeral Director: #

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3233 Superior Ln., Bowie, MD 20715

31. Date filed (Month, Day, Year) DEC 2 9 2008

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Dec 2008 PM **Physician** Dorothy Lee Warf Reed /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Calvert 2802 Ridge Road Huntingtown If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Days Hours Min. 100037 Day 929 1 M 2 SF 79 231-32-5993 Virginia Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at Huntingtown 1 ☐Yes 2 No Maryland Calvert Director 10g. Citizen of What Country? United States 10e. Street and Number 2802 Ridge Road 10f. Zip Code 20639 Funeral 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2K No Specify. white þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) US Post Office College (1-4or 5+) clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rilda Turner James Warf 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3501 Taylor Ave. Baltimore, MD 21236 19a. Informant's Name/Relationship (Type. Print) James Tench-son Date 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition central Cemetery Dec 30 2008 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Barstow Maryland 22. Name and Address of Facility Rausch Funeral Home 21. Signature of Euneral Service Licensee 4405 Broomes Is. Rd. Port Republic Maryland 20676 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each tipe. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last bus to (or as a consequence of) Examine The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Dav Year 4☐Pregnant at time of death 5 Other (specify) Yes ed by the a detached f 9 Unknown 9 I Unknown 23e. Did tobacco use contribute to the cause of death? page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 🎉 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 Injury Natural Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

within 24 the

> State Registrar

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mukesh Mathur, MD 110 Hospital Rd. Prince Frederick MD 20678 31. Date filed (Month, Day, Year)

DEC 2 9

32. Registra Signature 2008

29c. License number

29d. Date signed (Month, Day, Year)

Dec 29 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 12/28/2008 Physician 9:00 P M Joseph Charles Ruppert /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Carroll Westminster 310 Bishop Ct. 8. Date of Birth 06/25/1934 Birthplace (State or Foreign MD country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months 1 M 2 □ F 74 215-32-2825 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10h County items 23a or 28a-f show ner must be notified at 1 Yes 2 No Director Westminster MD Carroll 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21157 310 Bishop Ct. "natural", or items 23a edical Examiner must filed within 72 hours after death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Saltimore, Maryland 21215-0036 Specify: White þ 3 Widowed 4 Divorced Completed Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) 10 Cement Truck Driver permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygie Important: If item ZZ is marked other ti any injury or other traumatic event, th ones. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Vola Arnold Joseph Ruppert ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth Ruppert - wife 310 Bishop Ct. Westminster, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 12/29º/2008 20c. Location - City or Town, State 1 Burial 2 Decremation 3 Removal from State South Carroll Crematory 22. Name and Address of Facility
Myers-Durboraw Funeral Home
91 Willis St. Westminster 21. Signature of Funeral Service Licensee M01191 intai Willis St. Westminster, MD 21157 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imme liate Cause (Final disease or condition resulting in death) **Physician** 8 mouths NON Small Cell Lung Couch /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the death certificate be executed burial-transi Due to (or as a consequence of) Box 68760, attending physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy į in the past 12 months? 4□Pregnant at time of death 9□Unknown Month signed by the at d be detached for 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. or Vital Records, þ 1 Mes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No P 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident the Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or Att within 24 hours after d 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title

WSL

State Registrar Name and address

NAMAUC

Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) 32. Registrar's Signature

DEC 2 9 2008

no completed cause of death (Item 23a) (Type, Print)

South

D67468

12/29/08

DESTHILLSON, HD 21157

			1 - State Registrar	State of Marylan		artment of H <i>tificate of l</i>			gierie	, 0000
			Decedent's Name (First, Middle, Last)					2. Date of Dea	ath	3. Time of Death
	Physicia		Johanne Ross					Dec. 1	0, 2008 Year	10:15A <sup>M</sup>
	/Medic Examin		4a. Facility Name (If not institution, give st	treet and number)		4b. City, Town, or	Location of Dea	th	4c. County of Dea	ith
			9608 Napoleon Wa				mery V		Montgom	nery
	Funeral Director		5. Social Security Number 6. Sex 579-46-1667	7. Age (In yrs. 73	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	8. Date of Birth (Month, Day Dec • T	9. Bir 1, 1934 V	rthplace (State or Foreign ountry) irginia
	ъ		Usual Residence of Decedent							
	nylan show	_	10a. State 10b. County		y, Town or Lo					10d. Inside City Limits
	Be-f s	cto	MD Montgome	ery Mon	tgome	ry Vill	age			
	vith th	Funeral Director	10e. Street and Number	2.17		10f. Zip Code 20886			10g. Citizen of What C	ountry?
	s 23s	rai	9608 Napoleon Wa	2. Was Decedent Ever in U	C 13 V			Specify Ves or No.		erican Indian
_	Item Item	'n	11. Marital Status 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1.	Armed Forces?		Was Decedent of H f Yes, specify Cuba	in, Mexican, Pue	rto Rican, etc.)	Black, Whi	
2	urs af	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1□Yes 2█ No	Specify:		Specify:Ca	ucasian
2-003p	72 hours after death with the Maryland natural; or tems 23a or 28e-f show areal Examiliae must be indiffed at	Completed	15, Decedent's Educ (Specify only highest grade	ation	16a. Deced	dent's Usual Occup	ation	orkina	16b. Kind of Business	s/Industry
7	ithin lear.	nple	Elementary/Secondary (0-12)	College (1-4or 5+) 5 +		kind of work done o	1)	9	Dool Dot	
7	lygier her th	S	17. Father's Name (First, Middle, Last)	<b>D+</b>	Real	LOI	19. Mothoda Na	mo (First Middle	Real Est	.ace
yiand	be find he did h	Be	Hampton W. Ross					n Payne		
Ž	nark mark	<sup>L</sup>	19a. Informant's Name/Relationship (Typ	ne. Print)	19b. Mailir	na Address (Street			ar, City or Town, State,	Zip Code)
Z	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hyglene. Ifem 27 is marked other then "natural", or items 23a or 28e-f show other treumetic event, the Medical Examinating must be indifficed at		Susan Ross - Si		1					
ē,	s 1 and Head item		20a. Method of Disposition	20b. F	lace of Dispo	sition (Name of	ce)	Date	20c. Location - City of	r Town, State
Baitimor	permit. Pages 1 an Department of Heal Importent: If item 2 any njury or other once.		1 ☐ Burial 2 ACremation 3 ☐ Re 1 ☐ Donation 5 ☐ Other (Specify)	emoval from State Bak Cre	er-Pc matic	matory or other place OST On Cente	r Jan	.2,2009	Manassas.	Virginia
	mit. Porte y nju		21. Signature of Funeral Service License	9/	22	2. Name and Addres	ss of Facility B	aker-Po	st Funera	1 Home
מ	88 5 28		Whichael ( Vors	CC0424					anassas,	VA 20110
	Physician /Medical		234. Part1. Enter the disease, or complice shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	pations that caused the deat e cause on each line.	Lence of	er the mode of dyin	Inda r	ac or respiratory ar	rest,	Approximate Interval Between Onset and Death
	Examiner		f.	540 (0) 43 4 5011364	Co	(oneru	Artem	Disease	_	40.5
-		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	uence of):	1	-			
	icate be executed physician and s the burial-transit	Examiner	that initiated events C.							
Ď,	sian a	Ë	resulting in death) Last	Due to (or as a conseq	uence of);					
04/80 04/80	icate t physic s the b	edicai	d.							
×	certifi nding use as		IF FEMALE: 23	Bc. If yes, outcome of pregna	ancy				23d. Date of de	divery
X Q Q	res that the death certifigned by the attending be detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 🖺 No	1 Live birth 2 Feta	I death 3[	]Ectopic pregnancy ] Other (s <i>pecify)</i>	/		Month	Day Year
j.	t the c	hysi	9 Unknown	9□ Unknown						
ı,	requires that the een signed by th hould be detache	by P	Part II. Other significant conditions con-	tributing to death but not res	ulting in the u	nderlying cause giv	en in Part I.	23e. Did to	obacco use contribute t	to the cause of death?
ğ	w require been sig							1 🗆 \	Yes 2XNo 3∏F	Probably 4 Unknown
ecords,		Completed						24a. Was autop		utopsy findings available completion of cause of
<u> </u>	sicien: The law certificate has l irector, page 2 s	Con						perfo 1 Tyes	rmed? death? 2 No 1 □ Ye	s 252No
VItal	sicien: certifica irector,	Be	25. Was case referred to medical examiner?	ospital:		Oth		eatn (Check only o	nne)	
OI	this ald	To	1 ☐ Yes 2 No	1 ☐ Inpatient 2 ☐ 28a. Date of Injury	ER/Outpatier 28b. Time o		4 🗆 Nursing	-	dence 6 Other (Spanow injury occurred	ecify)
	ing After une	tion	1 S Natural 5 ☐ Pending	(Month, Day Year)	Injury	Wor	k?` Yes 2 □ No	200. 2030100 1	Towning occurred	
UNISION	Attending in death.	Certification:	3 Suicide 6 Could not be	28e. Place of Injury - At h				28f. Location (S	Street and Number or F	Rural Route Number,
5	el or s after of in t	Serti	4 Homicide	building, etc. (Special	<b>y</b> )			City or Tox	vn, State)	
	te Hospitel or Attend 24 hours after death te Funerel Director: ,	edical C		ician: To the best of my known to the basis of examination and manner stated.						
	To the Hos within 24 ho To the Func completely f	Meg	29b. Signature and title of certifier			29c. Licens		1	29d. Date signed (Mon	
-	(D		•	4	MD	00	×66526	6	Diccomber 2	9 2068
~	7		30. Name and address of person who con	mpleted cause of death (Iter	n 23a) (Type,	Print) Ay	Sha Jafe	i, M.D.		
			14955 SHADY (	ease Ro	SURCE	100	ilode	YSLLE	WD 200	824
				I applied a state of a patent						

DHMH 17 Rev 1/2001

Registrar

DEC 3 1 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend #7&8 Per Inf G889 3/16/09 JH
for Amend Item 25 per met year and / Henry He 43390 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** December Diane Meredith Rosendorf 30. 2008 0805 /Medical 4a. Facility Name (If not institution, give street and number) 4b City Town or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 74 9. Birthplace (State or Foreign Country) New York 6. Sex **Funeral** Months Days Hours Min 1 □ M 2 🖾 F 44 102-20-7186 April 30, Director Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show event, the Medical Examiner must be notified at Director 1 ☑ Yes 2 ☐ No Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with ō 620 Warfield Drive 23a 20850 United States Funeral items ; 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces? 1 ∐Yes 2 ⊠ No 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 Yes 2 No If Yes, Give Year or Dates: Specify. <u>Ş</u> Specify: White 3 ☐ Widowed 4 ☐ Divorced 'natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed within than, Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) None 0 None Pages 1 and 2 should be filed v nent of Health and Mental Hygie ant: If item 27 is marked other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Sidney Rosendorf ျှ Isabel Alvarez 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any Injury or other tra once. Isabel Rosendorf/Mother 620 Warfield Drive, Rockville, Maryland 20850 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) January 3, 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 2009 4 □ Donation 5 □ Other (Specify) Holy Cross Cemetery North Arlington, New Jersey permit. 21. Signature\_of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. M01548 300 West Montgomery Avenue, Rockville, Maryland 20850 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Myocardial Infarction disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events iner Due to (or as a consequence of) requires that the death certificate be execute Exami sician and burial-trans resulting in death) Last CERTIFICATION AS Due to (or as a consequence of) physician Box 68760 Physician/Medical th, attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a O TYes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records. Spastic Quadriplegia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has page 2 autonsy perform Division of Vital 2 X No 1 □ Yes 2 🖾 No 1 ☐ Yes 25. Was case referred to medical director Be 26. Place of Death (Check only one) Hospital: 1**X** Yes 2-₩0 Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA this After th funeral 28a. Date of Injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28d. Describe how injury occurred the Hospital or Attending 1 Natural 5 Pending investigation in 24 hours after death.

In Funeral Director: A pletely filled in by the funeral pletely filled in 2 Accident 1 ☐ Yes 2 🗆 No 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifie completely (Check only one) To the l 29b. Signature and litle of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3 11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 ara oles MD 990 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 15 2009 Registrar arks

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** SHYMA NSKY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 361 Colony Point Place Edgewater Anne Arundel 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Min. Months Days Hours 1 2 M 2 □ F 578-30-8481 81 11/11/1927 Director Pennsylvania Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a State 28a-f show items 23a or 28a-f show iner must be notified at **Funeral Director** 1 □Yes 2 M No Marvland Anne Arundel Edgewater 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 361 Colony Point Place 21037 12. Was Decedent Ever in U.S. Armed Forces?

1 ∑Yes 2 □ No WWII Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 7 Is marked other than "natural", or iten traumatic event, the Medical Examiner Black, White, etc. 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐Yes 21 No Specify: Be Completed by Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) <u>Electrician</u> Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) n and Mental H John C. Shymansky, Sr. Isabelle Ida Knott ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a 361 Colony Point Place Edgewater, MD. 21037 Gertrude P. Shymansky/Wife item 27 other to Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date t of H 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department o Important: If any injury or once. Lakemont Mem. Gardens 12/30/2008 Davidsonville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD. 21037 alas Approximate Interval Between Onset and Death s tivat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, so on each line. 23a. Part 1. Enter the diseas or complicati shock, or heart failure. List only one Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to for as a consequence of Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 TYes 2 No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 🗆 No 1∐Yes 2, 🗷 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2√No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State)

P.O. Box 68760, Division of Vital Records,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filted in by the funeral director, page 2 should be detached for use as the burla-transit

Medical Certification: To 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

29b. Signature and title of certifier

29dr Date signed (Month, Day, Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print) EFENSE HIGHWAY ANNAPAUS MODING, 31. Date filed (Month, 32. Registrar's Signature

State Registrar

			For State Registrar	State of Ma	aryland /	Dep Ce	artment of ertificate o	Health f <i>Deatl</i>	and M	ental Hy	giene Reg. No.	2008	43392
	Physicia	an	1. Decedent's Name (First, Middle, Las	t)			-			2. Date of De Month	Day	y Year	3. Time of Death
	/Medic		Dorothy M. Schlos				1			Decemb			
	Examin	er	4a. Facility Name (If not institution, given 1608 Arundel Road	street and number)			4b. City, Town, Edgew		n of Death		4c.	County of Dea	
۲	Funeral		5. Social Security Number 6. Se	•x _v 7. Ag€	(In yrs. last	birthday,	If Under 1 Yea	r   If Unde	er 24 Hrs. Min.	8. Date of Bir	th	9. Bir	thplace (State or Foreign
	Director		4/9-28-204/	□ M 2 🖟 F	82	Yrs.	Months Day	s Hours	IVIIII.	03/04/	1926	Was	shington
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	own or L	ocation						10d. Inside City Limits
	Mary a-f sh	ţo	Maryland Anne Aru	ndel	Edger	wate	r						1 □ Yes 2 No
	or 28;	Sire	10e. Street and Number				10f. Zip Code				10g. Cit	izen of What Co	ountry?
	ath wi	ral	1608 Arundel Road				21037					ted Sta	
320	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentall Hygiene. Department of Health and Mentall Hygiene. Important: If firen Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Marjord Examination unstition officed and once.	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☒ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☐ N If Yes, Give Year or Dates:	ever in U.S.	13.	Was Decedent of If Yes, specify Cu			cify Yes or No Rican, etc.)	-	14. Race - Ame Black, Whit Specify:	
മാഹാ	2 hou latura		15. Decedent's Edu	ucation	1:	6a. Dece	edent's Usual Occ	upation			16b. Ki	ind of Business	
<u>`</u>	ithin 7 ne. nan "n	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5-	+)		kind of work don DO NOT use reti	e during mo red)	ost of workin	9			
7	Hygier Hygier Ther th		12   17. Father's Name (First, Middle, Last)			Но	memaker	19 Mot	hor's Namo	(First, Middle,	Hom		
פטפ	d be t ental l ked ol c eve	To Be	Howard McNary							rchand	Waldell	Surriame)	
ar y	shoul and Ma s marl umati	ř	19a. Informant's Name/Relationship (7)		1	9b. Maili	ing Address (Stre	et and Num	ber or Rurai	Route Numbe	er, City o	or Town, State, .	Zip Code)
Σ :	and 2 ealth a n 27 ii		Howard Schlosser/	Husband			Arunde1		, Edge	water,	Mar	yland 2	21037
2	ges 1 It of H If iter or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ I	Removal from State	20b. Place ceme	of Dispo etery, cre	osition (Name of matory or other p	ace)	Da	ite	20c. Lo	ocation - City or	Town, State
	nt. Pa intmen intant: injury		4 ☐ Donation 5 ☐ Other (Specify)	)	Ft. 1		oln Cemt		12/29	/2008	Bren	twood,	Maryland
ם מ	Depar Impo any ir		21. Signature for the control of the				2. Name and Add						MD 21037
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only o	lications that caused	the death. D							water,	Approximate Interval Between
	hysician		Immediate Cause (Final disease or condition	Ren	al F	zile	nce.						Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	consequenc	ce of):							
		ē	Sequentially list conditions,	b. Due to (or as	DECTE	1.5 io	1						
1	outed ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c									
ָב ב	oe exe cian ar urial-ti	I Ex	resulting in death) Last	Due to (or as a	consequenc	ce of):							
00100	incate be executed physician and streets the burial-transit	edical		d				<del></del>					
Y Y		n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of								23d. Date of de	livery
	ed for	sician/M	in the past 12 months? 1 □ Yes 2 🕰 No	1 ☐ Live birth 2 4 ☐ Pregnant at 9 ☐ Unknown			☐ Ectopic pregnal ☐ Other <i>(specify)</i>					Month	Day Year
ָר רַ	d by the	Phys	9 Unknowh		4 4   <del>1</del>	- i Al		in and the Death		20° Dida			
'n.	signe d be d	۵	Part II. Other significant conditions co	numbuling to death bu	t not resulting	g in the t	indenying cause g	iven in Pari	. I.	1 🗆 Y		and the second	o the cause of death?
5	w required should	Completed	And the Control of th							24a. Was			itopsy findings available
ב ק	itte has	omp			**					autop perfoi	sy med/?	prior to	completion of cause of
ם פ	After this certificate h funeral director, page	Be C	25. Was case referred to medical examiner?					26. Plac	ce of Death	│ 1 □Yes (Check only o	2 <b>)2</b> No ne)	1 Li Yes	2 □No
> :	this ce	2	1 Yes 2 No				nt 3 🗆 DOA					6 □Other (Spe	cify)
	After funera	tion:	27. Manner of Death  1 Accident investigation	28a. Date of Injury (Month, Day)	y (Year) 28t	o. Time o Injury	W	uryat ork? ⊒Yes 2 [		8d. Describe h	ow injury	y occurred	
101	r deat ector: by the	ifica	3 Suicide 6 Could not be	28e. Place of Injul		farm, st				3f. Location (S	Street and	d Number or Ru	ural Route Number,
5 3	rs after al Dir	Certification:	4 ☐ Homicide determined	building, etc.	. (Зреспу)					City or Tow	n, State)	)	
1000	within 24 bounds after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Medical	29a. Certifier Certifying Phy (Check only one) Q Medical Example one)	vsiclan: To the best of iner: On the basis of and manner stat	examination ted.	and/or ir	nvestigation, in my	opinion, de	eath occurre	d at the time,	date and	place, and due	to the cause(s)
į.	vith com	Σ	29b. Signature and title of certifier	10			29c. Lice	nse number	<sub>pr</sub>		29d. Dat	te signed (Monta	h, Day, Year)
		}	(n)	W.			V5	8166	>	4	Sece	en Der L	15, 2008
(1	410		30. Name and address of person who of Eric C. Marcalus	ompleted cause of de	ath (Item 23)	a) (Type,	Print) Street	Suite	101 . 5	down	ter	ani) 7	n, Day, Year) 23, 2008
	Stat	te	31. Date filed (Month, Day, Year)	32. Registra	r's Signature	,	,		100	ryim	- /	1/	
	Registra	ar	DEC 2 9 2	1008 Dens	was a	9. 1	barker						

			For State Registrar	State of Ma	aryland		artment of H rtificate of				giene 20(	8 (	43393
	Physici	an							Date of Dea Month		/ear	3. Time of Death	
-	/Medi			11						ecembe	er 29, 20	800	4:25 A <sup>M</sup>
Ž	Examir	ner	4a. Facility Name (If not institution, g Casey House	ive street and number)			4b. City, Town, o		of Death		4c. County of Montgon		
	Funeral				e (In yrs. la	st birthday)	If Under 1 Year Months Days		r 24 Hrs. 8.	Date of Birth (Month, Day	1	9. Birtho	place (State or Foreign
	Director		n/a	1 □ M 2 🕅 F	74	Yrs.	World Days	Tiouis	_	un. 12		Cour ndi	
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	cation					1	0d. Inside City Limits
	Mary a-f sh	tor	India		Amri	tsar							1 ☐ Yes 2 ☐ No
	or 28	Dire	10e. Street and Number			COGI	10f. Zip Code			1	l0g. Citizen of Wh	at Cour	ntry?
	72 hours after death with the Maryland natural", or items 23a or 28a-f show digal Examinat must be notified at	by Funeral Director	56-C Gopaln Ager			140.1	143001				India		
10	fter de ritem instr	Fun	<ul><li>11. Marital Status</li><li>1 ☐ Never Married</li><li>2 ☐ Married</li></ul>	12. Was Decedent Armed Forces?			Was Decedent of H f Yes, specify Cuba	an, Mexica	an, Puerto Ric	y Yes or No- an, etc.)	14. Race - Black,	White,	
036	ral", or	by	3  Widowed 4 □ Divorced	1 ∐Yes 2V I If Yes, Give Year or Dates:			I∐Yes 2∏XNo	Specify	<i>/</i> :		Specify:	Ind	ian
21215-0036	72 hc "natur	Completed	15. Decedent's (Specify only highest of			(Give	dent's Usual Occup	durina mos	st of working		16b. Kind of Busi	ness/Ind	dustry
121	within ene. than	dmo	Elementary/Secondary (0-12)	College (1-4or 5	5+)	Homem	00 NOT use retired aker	d)			Own Home	<u>.</u>	
	other other	Be	17. Father's Name (First, Middle, Las	st)	l.			18. Moth	ner's Name (F	irst, Middle, I	Maiden Surname)		
ylar	Menta	To E	Daulad Ram					Lajw	andi D	evi			
Maryland	2 sho 2 and is ma raum:		19a. Informant's Name/Relationship				ng Address (Street						Code)
	1 and Health em 27		Rani Davi Sony/da	augnter			ple Grath		Germa		PID ZU8/ 20c. Location - Ci		wn State
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any Injury or other traumatic event, the Medical Examples once.		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec				sition <i>(Name of</i> natory or other place e1 Cremat				Odenton,		,
alti	permit. I Departm Importal any Inju		21. Sign we of Funeral Service Lic		VV •		Name and Addre						× 784
<u> </u>	8258		Dever I	telle	MO12	51 B	everly L.	Hec	krotte	, P.A.	Clarksv	i114	e, MD 21029
		5 57	23a. Part 1. Enter the disease, or co shock, or heart failure. List onl	mplications that caused y one cause on each lir	the death. ne.	Do not ent	er the mode of dyir	ng, such as	s cardiac or re	espiratory arr	est,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Maligna									
7	Examiner			Due to (or as	a conseque	nce of):							
	i i	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events	Due to (or as	a conseque	nce of):							
	xecute and I-trans	Examine	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as	a conseque	nce of):						$\perp$	
38760,	ficate be executed physician and s the burial-transit	dical E		Duc 15 (61 a5	a conseque	1100 01).							
	tificate ig phy as the	ledic		u									
Вох	eath certific attending p for use as i	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth			Ectopic pregnanc	v			23d. Date o		
0.	Physician: The iaw requires that the death certif this certificate has been signed by the attending ral director, page 2 should be detached for use as	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant a 9 ☐ Unknown	t time of dea	ath 5□	Other (specify)				Month		Day Year
σ.	uires that the de signed by the a d be detached to		Part II. Other significant conditions	contributing to death be	ut not result	ing in the ur	nderlying cause give	en in Part I	i. 1	23e. Did tol	pacco use contribi	ute to th	e cause of death?
rds	w requires been sign should be	ed by				-				1 □ Y∈	es 2 🗆 No 3	☐ Prob	ably 4 Unknown
Records,	a law requ has been e 2 should	Completed								24a. Was a	n 24b. We	re autor	osy findings available inpletion of cause of
<u>E</u>	: The I	Com							-	perforr	ned? dea	ath? Yes	
of Vital	siclan; Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:			t 3 DOA Oth		e of Death (C		-		7 .
10	ding Phys h. After this funeral di	n: To	1 ☐ Yes 2 ☐ No 27. Mapper of Death	28a. Date of Inju	ry 2	8b. Time of	t 3 DOA 28c. Injur Work	4 L.I NI			ence 6 Other ow injury occurred	(Specify	) hospice
ion	ending ath. or: Aft	atio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigati		y, Year)	Injury		k? Yes 2 🗆	]No				
Division	or Att	Certification: To	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		ury - At hom c. <i>(Specify)</i>	e, farm, stre	eet, factory, office		28f.	Location (St City or Town	reet and Number n, State)	or Rurai	Route Number,
	pital ours a leral C		29a. Certifier 1 ACertifying F	Physician: To the best	of my knowl	edge death	occurred at the tir	me date a	and place, and	I due to the c	auso(s) and man	20r 20 0	entod
	To the Hospital or Attending Pi within 24 hours after death.  To the Funeral Director: After the completely filled in by the funeral	Medical	(Check only 2 Medical Expone)	aminer: On the basis of and manner sta	f examinatio	n and/or in	vestigation, in my o	pinion, de	ath occurred	at the time, d	ate and place, and	due to	the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier	1. 10		)	29c. Licens	e number		2	9d. Date signed (/	Month, [	Day, Year)
			Phener 1	Upo Well	1815	mu)	D6461	L5		D	ecember	29,	2008
	1 EG		30. Name and address of person who Genevieve Wrobles					Rd.	Rocky	ille.	MD 20855		
	Sta	te		32. Registra	ar's Signatu	re			1.0000				
	Registr	31. Date filed (Month, Day, Year)  DEC 3 0 2008  32. Segistrar's Signature  B. January											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month THOMAS /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Howard County General Hospital Columbia Howard If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1X M 2□ F Director 215-07-2723 90 1918 Maryland Apr 17. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show item 27 Is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examinat must be notified at Director 1 ☐Yes 2 X No MD Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21042 5320 Dorsey Hall Drive #226 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1946–47 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐Yes 2X No Specify: White Specify. ğ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 (unk) (unk) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 12 should be fith and Mental Albert Thomas Swann. Sr. (unk) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) es 1 and 2 sh of Health and item 27 Is n Charles W. Simms/POA/Executor 10076 Century Drive Ellicott City, MD 21042 permit. Pages 1 and Department of He 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State injury or 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Important: It any injury or W. Arundel Crematory 12/29/08 4 ☐ Donation 5 ☐ Other (Specify) Odenton, MD 21. Signatur Funeral Service License Coing Home Cremation Service P.O. Box 784
Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Embo/sun Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate has been s rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Division of Vital 1 □ Yes 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Medical Certification: To 1 Dupatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mann f Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 1 UNatural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

State Registrar 31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15011 32. Registrar's Signature

D53987

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Pe 0624 M homas 2008 ohn December /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospit EASTON Talbot emoria If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 10 M 2 □ F Months Days Hours 239-60-063 Director March 9 Maryland Usual Residence of Decedent death with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1DeYes 2 □ No important: If item 27 is marked other than "natural", or items 23a or 28a-f st any injury or other traumatic event, the Medical Examination until for notified Director Talbut a57 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 2160 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🗹 No Baltimore, Maryland 21215-0036 Specify: Specify: Black þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Şecondary (0-12) College (1-4or 5+) Health and Mental Hygiene. County Board of Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1da lliaM Vlargaret 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mari Easton, Maryland 2160, 20c. Location City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date Pages 1 P 1 Burial 2 Cremation 3 Removal from State Robinson's Cemetery 12/27/08 Grasonville, 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Washington St. Cambridge, MD. 21613 HENRY Funeral 510 23a. Pard. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician est disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner be executed 075 sician and burial-trans Due to (or as a consequence of): Box 68760. physician Physician/Medical the aftending ph IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) P.O. 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed? Hospital or Attending Physician: The certificate 2 🗆 No Division of Vital 1 ☐ Yes 2 NO 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signature and title of pertifier 29c. License number 29d. Date signed (Month, Day, Year) Dxx65656 2008

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day,

Ta

2. pegistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

219

South

Street, Easten,

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** VIOLA B. SORRELL Year DECEMBER 20 /Medical 2008 9:10A 4a. Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death 4c. County of Death Examiner 5920 Sneed Drive Deale Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 M F Months Days Hours Min. 579-10-6959 Director 89 9/6/1919 Washington, Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show event, the Medical Examiner haust be notified at Director 1 ☐ Yes 2 ☐ XNo Maryland Anne Arundel Deale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 2 5920 Sneed Drive 20751 Funeral items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 ☑ No Specify White þ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th Home Homemaker Department of Health and Mental Hygie Important: If Item 27 is marked other I any injury or other traumatic event, it 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be Albert I. Bullock Viola Opdyke ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John B. Sorrell/Son 866 Bayview Dr., Edgewater, MD 21037 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) James' Cemetery 12/27/08 Lothian, MD 21. Signature of 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Road, Edgewater, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** tailure /Medical Due to (or as a consequence of): Examiner maestile Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar ulmonaru Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physician Physician/Medical the attending pt IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Year Dav 5 Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> Completed 1 ☐ Yes 2 No 3 Probably 4 Unknown director, page 2 should has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate performe 1 □ Yes 2 □ No 2 100 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 24 hours after death e Funeral Director: the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Light physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Light physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely (Check only one within 2 To the I 29b. Signature and title of certifie 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Marcalus 3169 Suite 101 C 2 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 43397 Certificate of Death 2. Date of Death 1, Decedent's Name (First, Middle, Last) Day Year **Physician** 3:07 pM 29 2008 Steiner December George /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Memorial Hospital Frederick If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year) Days 1⊠M 2□ F Months Hours Maryland May 17, 1918 Director 220-14-2155 90 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Silver Spring Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3012 Birchtree Lane 20906 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates:1944-1946 1 ☐ Yes 2 🖾 No Specify Specify. Completed by 3 ☐ Widowed 4 ☐ Divorced White 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 5+ Violinist/Professor Music 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bella Gross ၉ Jacob Steiner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health a Important: If item 27 is any Injury or other trau 10001 Dellcastle Road, Montgomery Village, Maryland 20886 Roslyn Price - Daughter Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/31/2008 Olney, Maryland Judean Memorial Gardens 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) 48 hours Urosepsis /Medical Due to (or as a consequence of) Examiner 1 year Renal Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician: The law requires that the death certificate be executed burial-tran attending physician and Due to (or as a consequence of): Physician/Medical the IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Year Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ð 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown Be Completed funeral director, page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy performed? this certificate 1 ☐ Yes 2K No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 🖾 ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred or Attending 5 Pending 1 X Natural after death. 1 ☐ Yes 2 🗆 No investigation 2 ☐ Accident the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral C 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier December 30, 2008 0 D0009748 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D., 10313 Georgia Avenue, Suite 105, Silver Spring, Maryland 20910 Alan Weinstock, 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 3 2008 Registrar

DHMH 17 Rev 1/2001

Box 68760.

P.O.

State of Maryland / Department of Health and Mental Hygiene ) Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 29, Veniamin December Shneyder 2008 9:30A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 10250 West Lake Drive Apt 308 Bethesda Montgomery Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 XM 2 □ F Months Days Hours Min Director 493-84-6693 83 9/13/1925 Ukraine Usual Residence of Decedent with the Maryland 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at MD Montgomery Bethesda Director 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10250 West Lake Drive Apt 308 permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s any Injury or other traumatic event, tra Medical Exprine mana any Injury or other traumatic event, tra Medical Exprine mana ongoes. Funeral 20817 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 
Yes 2 
No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Tes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No à Specify White Specify. 3 ☐ Widowed 4 🔯 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ <u>Plant Manager</u> Office Equipment 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Israel Shneyder ပ Nina Kolonsky 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Zoya Brodsky - Daughter 8611 Aqueduct Road Potomac MD 20854 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State National Crematory 4 ☐ Donation 5 ☐ Other (Specify) 12/30/08 Falls Church, VA 22. Name and Address of Facility
Edward Sagel Funeral Direction Inc
1091 Rockville Pike Rockville MD 20852 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Coronary Artery Disease disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter uncertying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
24 hours after death.
24 hours after death.
expension and bried of a After this certificate has been signed by the attending physician and stelly filled in privation and the property in the funderal director, page 2 should be detached for use as the burlat-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: iyes, outcome of pregnancy □Live birth 2□ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 □Yes 2 No 1 ☐ Yes 2 🖫 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∏-Yes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 🔀 Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00041311 2008 DECEMBER 30th 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Yuri A. Deychak MD 6410 Rockledge Drive Suite 200 Bethesda MD 20817 31. Date filed (Month, Day, Year) 32 Registrar's Signature State DEC 31 Registrar 2008

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 108 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month December 28, 2008 6:38 P M Beverly Seitz /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery 5705 Mayfair Manor Drive Rockville If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. (Month, Day, 6. Sex 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2X F Months Days May 26, New York Director 79 1929 128-22-0034 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the "Modical Event in a to notified at once. MD Rockville 1 XYes 2 No Montgomery Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5705 Mayfair Manor Drive 20852 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ XNo 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: White þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Preschool Teacher Assistant Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bessie Yanuck Moe Lyman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 139 Heritage Street Robbinsville NJ 08691 Ruth T. Seitz - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State Judean Memorial Grdns 12/31/08 Olney, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility
Danzansky-Goldberg Memorial Chapels Inc
1170 Rockville Pike Rockville MD 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myocardial Infarction **Physician** /Medical Due to (or as a consequence of): Examiner Atherosclerotic Cardiovascular Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown been signed by should be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has brieger, page 2 sl autopsy performed 1 ☐ Yes 2 📆 No 1 ☐ Yes 2 No r this certificaral director, p Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 🙀 Residence 6 ☐ Other (Specify) Hospital: 2 No Certification: To 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 Anatural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation ithin 24 hours after death.

the Funeral Director: Aff
ompletely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) within 24 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) December 30, 2008 D31840 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9715 Medical Center Drive suite 214 Rockville MD 20850 MD Wayne Meyer 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** SAFI 11:20 PM GRAZIA 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Montgomery Holy Cross Hospital Silver Spring If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Months Days 1 ☐ M 2 🖾 F Yrs. Director April 13, 1929 212-64-7172 Egypt Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Silver Spring Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number items 23a or by Funeral 20902 U.S.A. 610 Kenbrook Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 2 🖾 No If Yes, Give Year or Dates: Specify Specify: 3 Nidowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Health and Mental Hygiene. em 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12 Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ( Pages 1 and 2 should be nent of Health and Mental Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic evonce. Saad Wahba Rosa Cohen ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marie Topor - Daughter 10516 White Clove Terrace, Potomac, Maryland 20854 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ₺ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/31/2008 Olney, Maryland Judean Memorial Gardens 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Miglin T, Wobert Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ARRYTHMIA disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** CARDIOMYD PATHY Sequentially list conditions, if any Audio to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Completed by Physician/Medical Examiner Due to or as a consequence of Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23h. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? Year 5 Other (specify) 1 ☐ Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, RENAC 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

Hospital or Attending Physician: The law requires that the death certificate be executed 42 hours after death. Funeral Director: After this certificate has been signed by the attending physician and stely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Be (

Certification: To

Medical

1	1740074074	777		24b. We're autopsy infamings available prior to completion of cause of death?  1 □ Yes 2 □ No 1 □ Yes 2 □ No
١	25. Was case referred to medical		26. Place of Death (	(Check only one)
ı	examiner? 1 ☐ Yes 2 🂢 No	Hospital: 1   Inpatient 2 □ ER/Outpatient 3 □ E	OOA Other: 4 Nursing Home	e 5 ☐ Residence 6 ☐ Other (Specify)
	27. Manner of Death  1 Natural  2 Accident  5 Pending investigation		28c. Injury at Work? 1 ☐ Yes 2 ☐ No	3d. Describe how injury occurred
ı	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined		ory, office 28	<ol> <li>Location (Street and Number or Rural Route Number, City or Town, State)</li> </ol>
		hysician: To the best of my knowledge, death occurre miner: On the basis of examination and/or investigation and manner stated.		

D0067865

FOREST CLEN ROAD SILVER

29d. Date signed (Month, Day, Year)

SPRING

State Registrar

within 24 hours a

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

FARA H



MD

CHEEMA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



1500

			State of Maryland / Department	artment of Health and N rtificate of Death			0101
_	æ		1. Decedent's Name (First, Middle, Last)	Tillicale of Dealif	2. Date of Deat	eg. Nd2 0 0 8 4	Time of Death
	Physicia	an			Month	Day Year	
	/Medic		Mark Harrison Sain  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		24, 2008 10	:40 P <sup>M</sup>
1	Examin	er	27713 Barnes Road			· ·	
- 40		**	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Damascus  If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Montgomery 9. Birthplace	State or Foreign
	Funeral Director		290-32-5697 1XM 2□ F 70 Yrs.	Months Days Hours Min.	(Month, Day,	Year) Country) 4. 1938 Ohio	
	e de se		Usual Residence of Decedent				
	irylan ihow i at	_	10a. State 10b. County 10c. City, Town or Lo	ocation			side City Limits
	e Ma Ba-f s	Director	Maryland Montgomery Damascu				
	be filed within 72 hours after death with the Maryland that Hyglene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Dire	10e. Street and Number	10f. Zip Code 20872	1	0g. Citizen of What Country?	
	s 23a	ral	27713 Barnes Road  11 Marital Status 12. Was Decedent Ever in U.S. 13.		anifu Van ar Na	U.S.A.	tian
	item:	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 ☑ Married 1 ☑ Yes 2 □ No	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, etc.	1441,
30	rs aft	by F	3 Widowed 4 Divorced Year or Dates: 1961-66	1 ☐ Yes 2 🗓 No Specify:		Specify: Whit	e
2-003p	72 hours after natural", or ite ilcal Examine		15. Decedent's Education 16a. Dece	dent's Usual Occupation		16b. Kind of Business/Industry	
<u> </u>	nin 72 In "in Medik	plet	(Specify only highest grade completed) (Give life.	e kind of work done during most of worl DO NOT use retired)	king	Pharmaceutica	
7	d within giene.	Completed	4	Salesman		Products & La	b Testin
2	al Hy othe	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Nam	ne (First, Middle, M	Maiden Surname)	
<u>a</u>	uld b Menti Irked Itic e	To [	Ulysses Grant Sain II			ide Marquardt	
a L	2 sho and is ma auma		Total production of the control of t	ing Address (Street and Number or Ru	rai Route Number	, City or Town, State, Zip Code	9)
≥ .	s 1 and 2 should f Health and Mer item 27 is marke other traumatic			13 Barnes Road, Da		Maryland 2087	
ore O	<b>6 = </b> † 6		1 Burial 2 Cremation 3 Hemoval from State	osition (Name of ematory or other place)	Date	20c. Location - City or Town, S	itate
	F 65 3			Meth. Cemetery  2. Name and Address of Facility		Damascus, Mar	yland
gali	permit. Departi Importa any Inji		ha &	Molesworth-Willian			
				26401 Ridge Road,	Damascu or respiratory arre	s, Maryland App	20872 roximate
			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock or heart failure. List only one gause on each line.	. 1	1	Inter	val Between et and Death
No.	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. Due to for as a consequence of:	a ays 10	pry	de de	rodes
	Examiner		Due to tot as a consequence of the	Cardiami	Jaka 1	he We	Pane
Ь		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		1 Say	7 /	~~ / )
	uted d ansit	Examiner	Cause (Disease or injury that initiated events	e Neart Le	ulure	2 1/4	eurs
Ď	be executed ician and burial-transit	EX	resulting in death) Last Due to for as a consequence of):	1 declar	0 (	1	4,
3/60	cate be executed oblysician and the burial-transit	dical	d. Respirato	y Chiston	[ <i>]</i>	m	entry
õ	The law requires that the death certificate the has been signed by the attending physionage 2 should be detached for use as the	Med	IF FEMALE:	/			
X Q Q	leath certific attending p I for use as 1	ian/	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3	Ectopic pregnancy		23d. Date of delivery  Month Day	Year
	at the de by the a tached f	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of death 5 9 ☐ Unknown	Other (specify)			
1	that the		Part II. Other significant conditions contributing to death but not resulting in the u	underlying cause given in Part I.	23e. Did tol	pacco use contribute to the car	use of death?
Vital Records,	iw requires that s been signed t should be deti	d by	Ischemic bowel dis	Cease.	1 □ Ye	es 27 No 3 Probably	4 □Unknown
Ö	w req	ete			24a. Was a	n 24b. Were autopsy fi	ndings available
ě	sician: The law s certificate has b irector, page 2 s	Completed			autops perfori	prior to complet death?	ion of cause of
g			25. Was case referred to medical	26. Place of Dea	1 Yes ath (Check only on	2 No 1 Yes 2 □	No
	ysicia s cer	To Be	examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	Othor		ence 6 □Other (Specify)	
<u></u>	g Physical this heral di		27. Manner of Death 28a. Date of Injury 28b. Time (Month, Day Year) Injury	of 28c. Injury at Work?	28d. Describe ho	ow injury occurred	
Ö	ath. or: After he funer	atio	2 Accident investigation	M 1 ☐ Yes 2 ☐ No			
Division or	r Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, si building, etc. (Specify)	reet, factory, office	28f. Location (St City or Town	treet and Number or Rural Rou n, State)	ite Number,
	oital ours af			the annual at the time date and place			
	the Hospital or Attending Physician: In 24 hours after death. The Funeral Director: After this certification by the funeral director, the funeral director,	Medical	29a. Certifier 1 ☐ Certifying Physician: To the best of my knowledge, dea continuous one of the continuous of the conti				
	within 2 with 2 complete	Mec	29h Signature and title of certifier 1	29c License number	2	9d. Date signed (Month, Day,	Year)
/	124	1	Later W. Keverhw	1021126		December 26, 2	2008
	151	e	30. Name and address of person who completed cause of death (Item 23a) (Type				
/	147		Charles W. Karesh, M.D. 26033 Ridg	7	, Maryla	nd 20872	
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) 32/Registrar's Signature	parti			

Registrar
DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Yvette R. Smith 17 2008 2007 December /Medical 4a. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Annapolis Anne Arundel Medical Center If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. Aug 26 1959 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days Maryland 1 □ M 2**X**□ F 19 Yrs. 217-78-5557 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County show th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 1**X** Yes 2 □ No Director Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21401 13 Monument St. death \ Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Nursing Assistant Private Family 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be inent of Health and Mental Beatrice Adams Lenell Ponds ഉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health an Important; If Item 27 is any injury or other trauonce. 13 Monument St. Annapolis, Md. 21401 D'Mario Gray(Son) 20b. Ble South asture (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 12-23-08 Memorial Park Annapolis, Md. 4 ☐ Donation 5 ☐ Other (Specify) Minimame Receise of Scilis ons Mortuary, P.A. 21. Signature of Funeral Service Licensee Jarry B. Resse Mc0483 821 West St. Annapolis, Md. 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cardiomyonathy Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Day 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Metastatic breast caucer 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has al director, page 2 : autopsy performed? Yes 2 No 1 □ Yes 1 ☐ Yes 2 ☐ No al or Attending Physician: 's after death.'
I Director: After this certifica of in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 \(\subseteq\) Nursing Home \(5 \subseteq\) Residence \(6 \subseteq\) Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital or within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only 29d. Date signed (Month) Day, Year) 29c. License number 29b. Signature and title of certifier completed cause of death (Item 23a) (Type, Print) Pour kway anna fils, rep 32. Registrar's Signature 31. Date filed (Mon State 9 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 8:30 PM FRED H. SIEGEL DECEMBER 24 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ANNE ARUNDEL ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

JANUARY 27, 1925 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours Min. 1 X M 2 □ F NEW YORK 83 Director 133-16-1150 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐Yes 2X No Director GRASONVILLE MARYLAND QUEEN ANNE'S 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21638 UNITED STATES 1 KEEL HAUL DRIVE Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 **X**Yes 2 □ No If Yes, Give Year or Dates: **1943—1985** 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: WHITE δ 3 Widowed 4 Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Department of Health and Mental Hygien Important: If item 27 is marked other this any fujury or other traumatic successions. CERTIFIED PUBLIC ACCOUNTANT ACCOUNTING 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Be ROSALYN MAHLER MARTIN ABRAHAM SIEGEL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) KEEL HAUL DRIVE, GRASONVILLE, MARYLAND 21638 MADELINE P. SIEGEL/WIFE Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State DECEMBER 29 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State STEVENSVILLE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION 2008 21. Signature of Funeral Service Licente FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MARYLAND 21619 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequency f) /Medical Examiner neumonia Sequentially list conditions, if any loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy Month 5 ☐ Other (specify) signed by the a d be detached f 1 ☐Yes 2 ☐ No P.0. 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, <u>۾</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been si should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 🗆 No 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) æ Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After Hospital or Attending 24 hours after death. 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 🗌 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only

Registrar

31. Date filed (Month, Day, Year) **DEC 29** 

anoth

29b. Signature and title of certifier

Sohrabi AAMC MD gistrar's Signature 2008

MD

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical Pkny Annapolis, MD 2149 2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 43404 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Year **Physician** 1117 AM December 24 Marcella Pritchett 2008 Tolley /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Dorchester Dorchester Genera 1 Cambridge If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🖫 F 220-12-2342 84 July 19, 1924 Director Marvland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show other traumatic event, the Medical Exerciner roust be notified at XXYes 2 □ No Director Maryland Dorchester Cambridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 1102 Locust Street 21613 US Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or items 14. Race - American Indian, 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2√√No Specify: Specify: White 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Manager Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ford Pritchett Ada Meredith ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2::
Department of Health a
Important: If Item 27 is
any injury or other trau 1100 Glasgow Street Cambridge, Maryland 21613 Carol M. Haring Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory : 12/29/08 Salisbury, Maryland 22. Name and Address of Facility
Thomas Funeral Home, P.A. 21. Signature of Funeral Service Licensee 700 Locust Street Cambridge, Maryland 21613 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final hemorrhagic cerebral vascular occiden Physician disease or condition resulting in death) /Medical Due to (or as a consequence f) Examiner pertension Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner for use as the burial-transi resulting in death) Last Due to (or as a consequence of): attending physiciar Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 more Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy perform certificate 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗹 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir this 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical

State Registrar 31. Date filed (Month, Day, Year)

ancon de

Johnson

Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

Patricia.



and manner stated.

3altimore, Maryland 21215-0036

certificate be executed

Box 68760,

o

σ.

Division of Vital Records,

Tolley

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygien 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Leona LaMar Thrift December 20, 2008 6:15 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert County Nursing Center Prince Frederick Calvert 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months 1 M 2 KK 92 577~10-8338 October 16, 1916 Washington, Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits show th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, it a Mydical Exprimer mast be notified at 1 Tyes 2XXNo Directo Maryland Calvert Huntingtown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3534 Patuxent Road 20639 Funeral USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 NNo Specify: þ White 3123 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Department of Navy Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Margaret B. McKalvey Thomas A. Padgett ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any Injury or other trau once. Dianne Sanner / Daughter 3534 Patuxent Road Huntingtown, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State 12/27/2008 Cedar Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Suitland, Maryland Signature of Fundal vice Lica see 22. Name and Address of Facility George P. Kalas Funeral Home PA 2973 Solomons Island Road Edgewater, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician: The law requires that the death certificate be executed Exami attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗆 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 🖾 No Month Day 5 ☐ Other (specify) To the Hospital or Attending Physician: The law requires that the de within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached it 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 1 🔲 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 KNo 2 🗆 No 1 ☐ Yes 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 🖾 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) Hospital: 1 ∐ Yes 2 XXNo 1 🔲 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1XX Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of eleted cause of death (Ite //23a) (Type, Print) 2000 31. Date filed (Month 32. Registrar's Signature State 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar		State	of Mar	yland / Dep <i>Ce</i>	artmen ertificat				-	giene 0	08	434	06
	Physici	an	1. Decedent's Name	(First, Midd	e, Last)	-						2. Date of De Month		Year	3. Time of D	)eath
	/Medi	cal	June Ilea					41 61				Decembe		2008	12:00	$P^{M}$
1	Examir	ner	4a. Facility Name (If		_		ital	Oakl		Location of	of Death			nty of Death rett		
	Funeral		5. Social Security Nu		6. Sex		n yrs. last birthday	) If Under	1 Year	If Under	24 Hrs.	8. Date of Birt	th	9. Birthi	place (State or	Foreign
Н	Director		220-84-00	)44	1 ☐ M 2 🔀 F		79 Yrs.	Months	Days	Hours	Min.	(Month, Da April	5, 1929	9 West	Virgir	nia
	p >		Usual Residence of 10a. State	Decedent 10b. County			0c. City, Town or L									
	ehov	ŏ						.ocation							10d. Inside City 1 ☐ Yes 3	
	28a-1	Director	MD 10e. Street and Num	Garre	ett		Oakland	10f. Zip	Code				10g. Citizen	of What Cou		- (21/10
	3a or	۵	2002 Tabl		r Rd.				2155C	)			-	SA	nu y :	
	death ms 2	Funeral	11. Marital Status		12. Was D	ecedent Eve	er in U.S. 13.				gin? (Sp	ecify Yes or No Rican, etc.)	- 14. F	lace - Ameri		
9	or its	F	1 🗆 Never Marrie		ried 1 ⊟ Ye	Forces? s 2 No Give		1 Yes, spec		n, mexican Specify:	і, Риепо	Hican, etc.)		Black, White,	etc.	
8	72 hours after death with the Maryland natural, or Itama 23a or 28a-f show dical Examinar must be notified at	d by	3 XWidowed 4		Year o	Dates:						4	Spe	WI	nite	
21215-0036	in 72	Completed		fy only highe	t's Education st grade complete		(Giv	dent's Usua kind of wo DO NOT us	rk done a	<i>lurina</i> mos	t of work	ing	16b. Kind of	Business/In	dustry	
212	d within jiene. r than	mo	Elementary/Secon	idary (0-12)	College	(1-4or 5+)	Homer			,			Own 1	Home		
	be filed stat Hygi od other event, I	BeC	17. Father's Name (i	First, Middle,	Last)					18. Mothe	r's Nam	e (First, Middle,	Maiden Sum	iame)		
yla	should but and Ment	P	Alvey Rec							Berth	na L	iston				
Maryland	12 sh h and 7 ls m reum		19a. Informant's Na									al Route Numbe			Code)	
e,	1 and Health am 27 Ither to		Rachel He		ighter						-	akland,	MD 2.	1550	nun State	
mor	Pages nent of I int: if Its ury or o		,	Cremation	3 □Removal fro	III State	20b. Place of Disp cemetery, cre Underwood	_		)		2, 2009				
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Dopertment of Health and Mental Hygiene. Important: if Itam 27 Is marked other than "natural", or Itams 23a or 28a-1 show any njury or other traumatic event, the Madical Examinar must be notified as ODCS.		21. Signature of Fun	Service	Licensee	de	) 2	2. Name an	d Addres	s of Facilit	y Ne	wman Fun and, MD		Homes,		
			23a. Part1. Enter the shock, or hear	e disease, or	complications that	it caused the	e death. Do not en	ter the mod	e of dying	g, such as	cardiac o	or respiratory ar	rest,		Approximate Interval Between	
0	Physician		Immediate Cause (F disease or condition	inal	(	200	and a							1	Ons t and De	
	/Medical Examiner		resulting in death)		Due Due	to ( as a g	onsequence of):								1	1
	Examiner		Sequentially list con	ditions,	b	12	aclere	cope	9						My	5_
	ted nsit	Examiner	Sequentially list con if any, leading to im- cause. Enter Under Cause (Disease or in	nediate lying ⊸ njury	Jue	o (or as a c	ин <b>ѕе</b> циелсе of):									
	execunate and al-train	Exar	that initiated events resulting in death) La		c	o (or as a co	onsequence of):									
8760,	rate be executed physician and the burial-transit				d											
9	ng phi as th	Medi	IF FEMALE:													
P.O. Box	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the bural-transit	by Physician/Medical	23b. Was decedent in the past 12 n 1 ☐ Yes 2 ☑ 9 ☐ Unknown	nonths?		birth 2 g	Fetal death 3	⊒Ectopic pr ⊒ Other (sp						Date of delive Month	ary Day Yea	ar
	ss that gned b	y P	Part II. Other signific	cant conditie	ons contributing to	death but n	ot resulting in the t	ınderlying c	ause give	n in Part I.		23e. Did to	bacco use co	ntribute to th	ne cause of dea	ith?
ğ	equire en si ould b	fed	COPI	/ )	1/Empo	019	) t	120	ME			15 Y	es 2□No	3 Prob	ably 4 □Unl	known
Il Records,	ysician: The law r is certilicete has be director, page 2 sh	Completed	disord	En	freq	enfr	Tuzz					24a. Was autop	sy med?	D. Were auto prior to condeath? 1 Yes	psy findings avangletion of cau	ailable se of
<u>Zita</u>	ician: Th certificete ector, pag	Be	25. Was case referre	ed to medical			2				of Death	Check only or				
0	ਦ ਵਾਲ	2	1 ☐ Yes 2 ☐ N 27. Manner of Death	16		Inpatient e of Injury	2 ER/Outpatie			4 🔾 1401		me 5 Resid			1)	
0	Attending Physician: If death. Setor: After this certifice by the funeral director, is	atlon	1 ☑ Natural 2 ☐ Accident	5 Pendin	g (M	onth, Day Ye	ear) Injury	M Z	8c. Injury Work 1 □ Y	at ? ′es 2.∐h		28d. Describe h	ow injury occ	urred		
Division of Vital	al or Atte s after dei il Directo id in by th	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could determ	inod   259, Pla	ce of Injury Iding, etc. (5	- At home, farm, st Specify)	reet, factory	, office			28f. Location (S City or Tow		mber or Rura	l Route Numbe	Γ,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier (Check only 2 one)	Certifyin	Examiner: On the	he best of m basis of exa anner stated	ny knowledge, deat amination and/or in	h occurred avestigation,	at the time in my op	e, date and inion, deat	d place, a	and due to the deed at the time, o	ause(s) and a date and place	manner as st e, and due to	ated. the cause(s)	
	To the within 2 To the complet	Σ	29b. Signature and ti	itle of certifie		10	0	290	License	number			29d. Date sign		1	
,		-	30. Name and addres	ss of person	who completed ca	use of death	(Item 23a) (Type	Print)	160	060	80		12	130	108	
			Kenneth	Buczyn	ski, M.D	., 311	N. Four		., Si	ui.te	1, C	akland,	MD 2	1550		
	Sta Registr		31. Date filed (Month	AN - 6	2009	Registrar's										
-				U		enera	1 19. 14									

DHMH 17 Rev 1/2001

1 - For State Registrar

			State     Registrar		C	Certifi	cate of l	Death		1	Reg. No.	nna	1.34.07
ı	Dharisi		1. Decedent's Name (First, Middle, Las	t)					2	Date of Dea	ath Day	Year	3. Time of Death
	Physicia /Medic		Teresa Edna	Tyler					Ī		BER 7		OS 1007 AM
The same	Examin		4a. Facility Name (If not institution, give			4b.	City, Town, or	Location of	f Death		4c. Co	unty of Deat	h
an shi	<b>}</b>		Washington County				lagerst					shing	ton
	Funeral		5. Social Security Number 6. S	ex □M 2X F 7. Age (In 8.	yrs. last birtho	Mo	Inder 1 Year nths Days	If Under 2 Hours	Min.	. Date of Birt (Month, Da	v. Year)	9. Birt	hplace (State or Foreign untry)
	Director		578-36-3659 Usual Residence of Decedent	0	3 '''	3.			P	lay 25	, 1925	Wash:	ington, D.C.
	land ow		10a. State 10b. County	10c	. City, Town o	r Location	n						10d. Inside City Limits
	Mary f sh	tor	Maryland Carroll		Mount	Airs	7						1 □Yes 21X No
	the 28a	Directo	10e. Street and Number		110 411 6		of. Zip Code	-			10g. Citizen	of What Co	untry?
	72 hours after death with the Maryland Inatural", or items 23a or 28a-f show Jipal Examiner must be reditiod at		2411 Braddock Ro	oad				21771			U.S	. A.	
	death rms 2	Funeral	11. Marital Status	12. Was Decedent Ever	in U.S.	13. Was I	Decedent of Hi , specify Cuba			fy Yes or No		Race - Ame	
Q.	after or ite		1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give			es 2 XNo	Specify:	, ruello ni	can, etc.)		Black, White	
5-0036	ral",	d by	3 Widowed 4 □ Divorced	Year or Dates:			63 2 2010	оресну.			Sp	ecify: V	White
,	within 72 hours after death with the Marylan jann - than "natural", or items 23a or 28a-f show It e Madical Examinat must be notified at	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a. D	ecedent's Give kind	Usual Occupa of work done o OT use retired	ation during most	of working		16b. Kind o	of Business/I	industry
[2]	within jiene. r than "	шp	Elementary/Secondary (0-12)	College (1-4or 5+)			<i>OT use retired</i> naker	1)			0		
N	e filed wall Hygie other t	ပိ	17, Father's Name (First, Middle, Last)		1	TOMER	lakel	18 Mother	r's Name (i	First, Middle,		n Home	2
ä	4 2 a e	Be							,			name)	
Maryland	should be filed and Mental Hyg s marked other umatic event,	70	Thomas R. Nal	ley, Jr.	10h A	Inition Ad	dress (Street		ellie		<i>-</i>	um Stato 1	Zin Codo)
Z Z	d 2 s th an t7 Is						•				,		. ,
á,	ages 1 and 2 should bent of Health and Ment it: If item 27 Is marked or other traumatic e		Catherine Harich 20a. Method of Disposition	- Granddaugi	b. Place of D	isposition	(Name of	1	aa, Dat	e	20c. Locati	Mary I ion - City or	Land 2177] Town, State
o E	Pages nent of int: If its iry or o		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Dopation 5 ☐ Other (Specification 5 ☐	Removal from State			y`o <i>r other pl</i> ac Method	1	2/20/	00	77 .		
altimore,	교문원들 .		21. Signature of Funeral Service Licen		TOVIGE	22. Nar	ne and Addres	ss of Facility	v				<u>laryland</u>
ñ	Depa Impo any l		KIVAT	2. Hier	w	Mole	sworth	-Will:	iams	P.A.,	Funera	al Hom	ne
			23a. Part 1. Enter the disease, or com-	olications that caused the	death. Do not	enter the	1 Ridge mode of dyin	e KOao ng, such as≰	cardiac or i	<b>amascu</b> respiratory ar	rest,	ryland	Approximate
,	Physician		shock, or heart failure. List only immediate Cause (Final	one cause on each line.	a nic	20	Hom	088/	Lagi	2			Interval Between Onset and Death
1	/Medical		disease or condition resulting in death)	Due to (or as a cor	nsequence of)	: U	11600	00-7	-8				DH I
محيمه	Examiner												
•	D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a cor	nsequence of)	:							
	scute ind trans	Examine	Cause (Disease or injury that initiated events	c							_		
Š,	oe exe		resulting in death) Last	Due to (or as a cor	sequence of)								
98/PU	certificate be executed ding physician and se as the burial-transit	/Medical	•	d				-					
ς ×	ertifi ding l	Me	IF FEMALE:	23c. If yes, outcome of pro-	ognanov.						TG-C		
	death of attention of for us	ian	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 4 Pregnant at time	Fetal death		opic pregnancy er (specify)	y			23d.	Date of deli Month	Day Year
o	e law requires that the death cer has been signed by the attendin je 2 should be detached for use	Physiciar	1 □ Yes 2 ☑ No 9 □ Unknown	9 Unknown	or death	3 L O(1)	er (specify)						
Л	requires that the been signed by th hould be detache		Part II. Other significant conditions	ontributing to death but not	t resulting in th	ne underly	ring cause give	en in Part i.		23e. Did to	bacco use	contribute to	the cause of death?
ecords,	n sign	d by	+604018	tenside	1					101	es 2	о 3 □ Pr	obably 4 🗌 Unknown
ဝ္ပ	law rec as bee 2 shou	lete								24a. Was	an 2	4b. Were au	topsy findings available
Ä	he la te ha: age 2	Completed								autop	rmed?	prior to death?	completion of cause of
VITA	an: 7 rtifica tor, p	e l	25. Was case referred to medical		,			26. Place	of Death (	1 □ Yes Check only o		1 Li Yes	2 No
>	ysici is ce direc	.o B	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	2 ER/Outp	atient 3	□ DOA Othe	er: 4 🗆 Nur	rsing Home	5 ☐ Resid	dence 6 🗆	Other (Spe	cifv)
סר	ng Ph terth neral	T:UC	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Yea	28b. Tin (ar)		28c. Injun Work	y at	28	d. Describe h	ow injury oc	curred	
<u> </u>	endir sath. or: Al	atic	2 ☐ Accident investigation	1		N	1 1 1	Yes 2□N	No				
DIVISION	irector by t	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - building, etc. (Si	At home, farm becify)	, street, fa	actory, office		28	f. Location (S City or Tou		umber or Ru	ıral Route Number,
ם	ital o Jrs af ral D	Cel											
	To the Hospital or Attending Physician: The I within 24 Hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	ledical		ysician: To the best of my niner: On the basis of exa and manner stated.									
	o the	Mec	29b. Signature and the of certifier	and harmer stated.	1	-	29c. License	e number	A		29d, Date ≰i	gned (Month	Day (Year)
	P S P O			0			D	41/	86		121	23	100
	(90)		30. Name and addless of person who	completed cause of pleash	(Item 23a) (I	pe-Print	\ \ \		1	11 0:1	0 1	2-0-0	100%
	W		J. Hlench	Gred MI)	1 6	\$ 0	4100	MA	hil	I ANY	1 46	BE82	178217(C)
	Sta		31. Date filed (Month, Day, Year)	33 Begistrar's S	Signature	Bank	12 9				7	1	11)21172
	Registr	ar	TEC 2 9 21	108 Bana	D. F	A STATE							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death **Physician** 319 M Anna Louise TATE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Washington Hagerstown 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year) Months 93 207-16-7480 12,1915 Director Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show Department of Health and Mental Hygiene. Important: if Item 223a or 28a-f show important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It a Medical Experience must be multified at once. Maryland Washington 1X Yes 2 □ No Director Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1175 Professional Court 21742 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐Yes 2X No Specify. white Specify: 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Nursing Assistant unknown unknown unknown 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Peter Dierling ပ Anna Warner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christine Gostowski-granddaughter 8373 Revelation Ave., Walkersville, MD 21793 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ₺ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery 12/26/08 Hagerstown, Maryland 22. Name and Address of Facility MINNICH FUNERAL HOME 21. Signature of Funeral Service Licensee 415 E. Wilson Blvd., Hagerstown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or es e conse ueno of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit P.O. Box 68760, Physician/Medical yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death
☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) I ☐Yes 2 ☐ No cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ 124 hours after death. e Funeral Director: After this 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 12 | 22 | 08 | 07:20 A M 27. Manner of Death 28d. Describe how injury occurred Certification: Division 5 ☐ Pending investigation 1 Natural Ground level 1 ☐ Yes 2 No tall 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) + Lagcrs tow 1175 Professional Cow+ mp 4 Homicide Hagerstown broadmore ASSISKA LIVING 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely To the within 2 and manner stated. 29b. Signatur 29c. License number 29d. Date signed (Month, Day, Year) 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SH-5 251 C And A 32. Pegistrar's Signature 31. Date filed (Month, Day, Year) State JAN 0 5 2009 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM#2perPHYS G889 3/1//09 WS State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month DINGS 0405 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 213 Admiral Dr. Annapolis Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Bay, Mar 8 **Funeral** 9. Birthplace (State or Foreign 1□M 2□ F Months Days Hours Min. 219-74-6851 51 Yrs. Maryland Director Usual Residence of Decedent ould be filed within 72 hours after death with the Mary/and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits Director Maryland Anne Arundel Annapolis 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 213 Admiral Dr. 21401 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No ģ Specify. 3 Widowed 4 Divorced Specify: Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: if item 27 is marked other tha any injury or other traumatic event, its once. 10th Housewife 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) James H. Henderson Sr. ပ Anna Cromwell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wesley L. Tydings Sr(Husband) 213 Admiral Dr. Annapolis, Md. 21401 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veteran | 12-22-08 Crownsville, Md. 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee Windame Recogned & Collisions Mortuary, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. 821 West St. Annapolis, Md. 21401 t and Death **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 No 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Day Year Month 5 Other (specify) signed by the 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? has 24a. Was an autopsy certificate 1 ☐ Yes 2 ☐ Mo 2 🗆 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 5 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending I Director: / 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide n 24 hours aft e Funeral Di letely filled ir Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) within 2 29b. Signature and title of certific 29c. License number u

Registrar
DHMH 17 Rev 1/2001

State

Name and address of person

31. Date filed (Month

vho completed

1 9 2008

744

DEFENSE HIGHWAY ANNAPOUSMO 21401

cause of death (Item 23a) (Type, Print)

Registrar's Signature

amend line aaco hlth d	2 de	per phy	y <b>Pleas</b> 3/08 d	se Type or lw State	Print of Ma	t in Bl rvland	ack Ind	delible   artment	<b>lnk.</b> of H	Ensure	e <b>All</b> nd Me	Copies	Are	Legi	ble.		
Physicia		State Registrar  1. Decedent's Name		·				rtificate				2. Date of De	Reg. N	.20	08 /20	0 83. Time o	
/Medica	al	4a. Facility Name (I	If not institution.	give street and n	. 4 .	nl		4b. City. To	wn. or	Location of [	Death	<del>(</del>	12	c. County	of Death	-	M A
Examine		Mandrin	Chesape	ake Hosp	oice			Harv	v000	£				Anne	Aru	ndel	
Funeral Director		5. Social Security N 077-26-8 Usual Residence of	313	6. Sex 1 <b>∑</b> M 2□ F	7. Age	76	st birthday) Yrs.	If Under 1 Months [	Days	If Under 24 Hours	Min.	B. Date of Bi (Month, D Dec.	rth lay, Year 02 <b>,</b> 1	932	9. Birth Con New	nplace (State untry) Y York	or Foreign
Maryland I-f show	tor	10a. State MD	10b. County	rundel			Town or Loc erna I									10d. Inside 0	City Limits
h with the	Funeral Director	10e. Street and Nur 637 Tewk		Lane				10f. Zip Co	ode 114	5	-		_	itizen of V USA	Vhat Cou	untry?	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantine must be notified at once.	2	11. Marital Status 1 ☐ Never Marri 3 ☐ Widowed		12. Was De Armed F 1 XYes If Yes, G Year or	Forces? 2 □ No Bive	ver in U.S. 1956 1959	o~	Nas Deceder fYes, specify		spanic Origin n, Mexican, F Specify:	i? (Spec uerto Ri	ify Yes or No can, etc.)	0-		k, White	ican Indian, , etc. ite	
215-C thin 72 hc e. an "natu Wedien	Completed	(Spec		grade completed College	() (1-4or 5+		16a. Deced (Give life. L	lent's Usual ( kind of work of OO NOT use	done d retired,	ation <i>Juring most of</i> )	f working		1	Kind of Bu		Ť	
be filed wintal Hygier the event, the	e B	17. Father's Name		*				Manag	ger	18. Mother's			e, Maide			Compa	ny ———
Baltimore, Maryland 21215-0036  bermit. Pages 1 and 2 should be filed within 72 hours att Department of Health and Mental Hygiene.  mportant: If them 27 is marked other than "ratural", or any injury or other traumatic event, the Medical Eventione.	2	19a. Informant's Na Nancy R.	ame/Relationsh	p (Type. Print)				ng Address (S		and Number o	or Rural		ber, City				
more, ages 1 an ent of Hea it: If item 2		20a. Method of Disp	position	3 ☐ Removal fron			ce of Dispo: netery, cren	sition (Name natory or other	of er place	De	Dat	6,	20c. I	Location -	City or T	own, State Maryla	
Baltii permit. P Departm Importar any injur		21. Signature of 50				1										neral D 2114	
Physician /Medical Examiner  portial-transit	Examiner	23a. P. 1. Enter the shock, or hea Immediate Cause (disease or condition resulting in death)  Sequentially list conif any, leading to impause. Enter Indecause (Disease or that initiated events resulting in death) I	nd failure. List of (Final on	a b Due to	o (or as a	2.	nce of):		of dying	g, such as ca	rdiac or	respiratory a	arrest,			Approxima Interval Be Onset and	etween Death
9 .9 5	Physician/Medical E	IF FEMALE: 23b. Was decedent in the past 12 1 ∐Yes 2 [ 9 ☐ Unknown	months? ☐No		birth 2	f pregnand □ Fetal d time of dea	eath 3	Ectopic preg		,				23d. Dat		-	Year
cords, P w requires that the pean signed to should be dete	2	Part II. Other signif	ficant condition	_	death but		ng in the ur	nderlying caus	se give	n in Part I.						the cause of	,
Division of Vital Records, of or Attending Physician: The law requires the after death.  Director: After this certificate has been signed in by the funeral director, page 2 should be death.	Completed								-		_	24a. Was auto perfe 1 □ Yes	psy ormed?	[	rior to c leath?	opsy findings ompletion of	available cause of
of Vital Re Physician: The Is rthis certificate ha	To Be	25. Was case referrexaminer? 1 ☐ Yes 2 ☑		Hospital: 1	Inpatien	ıt 2□EI	R/Outpatien	t 3 DOA	Othe	26. Place of		Check only 5 ☐ Res		6 DOth	er (Soec	ifu hos	n)U
Division of To the Hospital or Attending Phylinin 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral v	ation: 1	27. Manner of Deat 1 Natural 2 Accident	5 ☐ Pending investiga	(Mo	e of Injury onth, Day,	Year) 2	8b. Time of Injury	28c	. Injury Work 1 □ Y		28	d. Describe				.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
Divis Hospital or Atte Puncing affer de Puncing affer de Puncing filled in by it	Certification:	3 ☐ Suicide 4 ☐ Homicide	6	ned 28e. Plac buil				eet, factory, o				City or To	wn, Sta	te)		ral Route Nur	nber,
To the Hospi within 24 hou To the Funer completely fil	Medical	29a. Certifier (Check only one)	P Medical E	Physician: To the xaminer: On the and ma	ne best of basis of e nner state	examinatio	edge, death on and/or inv	n occurred at vestigation, ir	the tim	ne, date and pinion, death	place, ar occurred	d due to the	e cause( , date ai	s) and mand place,	anner as and due	stated. to the cause(	s)
E WY SON	)	29b. Signature and	infe of certifier	Dip				29c. L	icense ) b _	number	2		29d. D	ate signed	(Month	, Day, Year)	
S/BP		30 Name and addr	$\gamma$	1650 V	av	OK	433a	Print)	20	Si	ise	300	4	200	. (1)	15 21	401
State Registra	-	31. Date filed (Mon	DEC 23	2008 32.	Registrar	's Signatu	19. As	arks									

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Ye ar **Physician** Mary Miller Vroom PM 2008 9:49 December 20, /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Anne Arundel Anne Arundel Medical Center Annapolis | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Feb. 2, 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign Social Security Number **Funeral** Months 229-18-4101 1 □ M 2XX 92 Virginia Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State "natural", or items 23a or 28a-f show adical Examiner must be notified at Anne Arundel Annapolis Maryland 1XXXes 2 □ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 121 Monticello Avenue 21401 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ②CXNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □Yes 2\(\overline{\Omega}\)
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: White Baltimore, Maryland 21215-0036 1 ☐Yes 2 X No Completed by 3℃Vidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 7 is marked other than "natural traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bertha Vonderlehr Joseph L. Miller permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic en once. ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Karen E. Powers/daughter 121 Monticello Avenue Annapolis, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State Gate of Heaven Cemetery 12/27/2008 Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signature of Funeral Service Licensee 147 Duke of Gloucester St., Annapolis, MD 21401 000 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Weeks Immediate Cause (Final Cerebrovascular Accident **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Hypertension years Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): burialnding physician a Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant atter for u 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ned by the a 1 ☐ Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part !. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ sign I be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 2 □ No 1 ☐ Yes 2 X X C 1 ☐ Yes To the Hospital or Attending Physician; 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ∐ Yes 2 XNo 1 ☐ Inpatient 2 ☐ POA ၉ this 28a. Date of Injury (Month, Day, Year) within 24 hours after death.

To the Funeral Director: After the 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical

Registrar

(Check only one)

Michael J. LaPenta, MD

29b. Signature a

Box 68760.

o

σ,

2 Medical Examiner: On the basis of examiner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

445 Defense Highway

unination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Annapolis, Maryland

29c. License number

D21438

29d. Date signed (Month, Day, Year)

December 22, 2008

			For	State	of Marylan	d / Depa	artment of H	ealth and	Mental Hyg	iene		
		•	<ul> <li>State Registrar</li> </ul>			Cei	rtificate of E	Death	R	eg. No. 2	0.8	43412
			1. Decedent's Name (First, Middl	e, Last)					2. Date of Dear	th Day	Year	3. Time of Death
	Physicia /Medic		SOM	PHIENG	VIR	ASANE			DEC. 2			11:12 P <sup>M</sup>
	Examin		4a. Facility Name (If not institution	n, give street and n	umber)		4b. City, Town, or	Location of Deat	h	4c. County	of Death	
			WASHINGTON					IA PARK	10.51 (5:4		TGOME	
	Funeral		5. Social Security Number	6. Sex 1 <b>X</b> M 2 □ F	7. Age (In yrs. I	la <i>st birthd</i> ay) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month, Day	Year)	Coun	
	Director		577-04-1580 Usual Residence of Decedent		67				JAN. 2	, 1941	L	OAS
	land ow		10a. State 10b. County		10c. City	y, Town or Lo	cation				10	0d. Inside City Limits
	Mary Fr sh	ţ	MD. PRINCE	E GEORGES			HYATTSVI	ILLE				1XTYes 2□No
	r 28s	Director	10e. Street and Number				10f. Zip Code	<del></del>	1	0g. Citizen of V	Vhat Coun	try?
	h wit		2729 NICHO	DLSON ST.	#201		2078	32		]	LOAS	
	ems ems	Funeral	11. Marital Status	12. Was De Armed F	cedent Ever in U.:	S. 13.	Was Decedent of Hi	spanic Origin? (S	pecify Yes or No-		e - Americ k, White, e	
36	after or It		1 Never Married 2 Marr	ried 1 Tyes	2 No Sive		1 ☐ Yes 2 🛣 No	Specify:		Specify	<b>'</b> :	2.6
21215-0036	be filed within 72 hours after death with the Maryland that Hygiene.  Indicate than "natural", or Items 23a or 28a-f show other than "natural", or Items 23a or 28a-f show event, I've Medical Exoniner must be notified at	d by	3 Widowed 4 Divorced		Dates:	16a Doos	dent's Usual Occupa	ation		16b. Kind of Bu	AS	IAN
5	"na	Completed	(Specify only highe	T		(Give	kind of work done d DO NOT use retired	luring most of wo	rking	TOD. KING OF BU	15111655/1110	ustry
12	filed within 72 Hygiene. <b>xher than "na</b> i ant, <u>ire Medic</u>	E	Elementary/Secondary (0-12)	College	(1-4or 5+)		DISHWASH			MAYF	LOWER	HOTEL
	filed Il Hygi other ent, I	BeC	17. Father's Name (First, Middle,	Last)					ne (First, Middle, i	Maiden Surnam	ie)	
Maryland	should be filed withir nd Mental Hygiene. marked other than matic event, Ine M	10 E	MALNOU	NE	VIRASA	NE			SIVILAY	V:	IRASA	NE
ary	s 1 and 2 should f Health and Mer Item 27 is marke other traumatic		19a. Informant's Name/Relations	ship (Type. Print)		19b. Mailin	ng Address (Street a	and Number or R	ural Route Numbe	r, City or Town,	State, Zip	Code)
	and and and and n 27 in 27 in the tra		INTHAVA KEOSON	MBATH/WIF			NICHOLSON	N ST. #2				
ore	% O		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation	3 ☐ Removal from	l c	lace of Dispo emetery, crei	sition (Name of natory or other place	θ)	Date	20c. Location -	City or To	wn, State
altimore,	Pages tment of tant: If It jury or o	. 9	4 □ Donation 5 □ Other (S		СН		CREMATOR		-2009	RIVER		
Ba	permit. Pages Department of Important: If I any Injury or once.		21. Signature of Funeral Service	Milleur Milleur	<b>M</b> 000	91   2	Name and Addres CHAMBERS I 801 CLEVI	is of Facility FUNERAL 1 ELAND AV	HOME & CI	REMATOR	IUM,P MD. 2	0737
			23a. Part 1. Enter the disease, or shock, or heart failure. List	r complications that	caused the death	n. Do not en	er the mode of dying	g, such as cardia	c or respiratory arr	est,		Approximate Interval Between
1	Physician	n i	Immediate Cause (Final disease or condition	H	5PAT	TIL	3 C	+				Onset and Death
	/Medical Examiner		resulting in death)	Due to	o (or as a consequ	uence of):		2 - ( - 0	·			
	Lxammer	_	Sequentially list conditions,	b	lor as a consequ	2 C	0200	1000>	/>		_	
7	ted nsit	in	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due	TA-63	(2) (E)	- Me	711	7715			
<u>,</u>	execu n and al-tra	Examiner	that initiated events resulting in death) Last	c. Due to	o (or as a consequ		7 1.00	2	2005			
8760,	cate be executed physician and the burial-transit	dical		Ca. 13	ACTE	2NE	AZ S	200	C 54	OU/.		
		Med	IF FEMALE:									
Box	eath certific attending p	an/l	23b. Was decedent pregnant in the past 12 months?	1 ☐ Liv	utcome of pregna e birth 2 ☐ Feta	Ideath 3[	☐ Ectopic pregnancy	/		I	te of delive	ery Day Year
O.	ie dea the at	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 □ Pre 9 □ Uni	gnant at time of d known	leath 5	Other (specify)			1010	11111	Day real
<u>.</u>	that the de ned by the detached	된	Part II. Other significant conditi	ons contributing to	death but not resu	ulting in the u	nderlying cause give	en in Part I	23e. Did to	bacco use cont	ribute to th	ne cause of death?
Vital Records,	8 5 8	i by	Tar III o III o II o II o II o II o II o	one contributing to	douti but not root	annig in and a	naon, ng sauco gno					eably 4 Unknown
Ö	w requir been si should I	etec							24a. Was a	n   24h	Moro outo	psy findings available
Re	ne law e has ge 2 g	Completed							autops perfor	med2	prior to con death?	mpletion of cause of
			25. Was case referred to medica	1				06 Pings of Do	1 ☐ Yes ath (Check only on		1 □Yes	2 □ No
		o Be	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	Inpatient 2	FB/Outpatie	ot 3 DOA Othe	Nr.	dome 5 ☐ Resid		er (Specif	iv
o	<b>-</b> = □	n:T	27. Manne eath	28a. Dat	e of Injury onth, Day, Year)	28b. Time o		y at	28d. Describe h			,,
0	ath. r: Aff	atio	1	gation	min, Day, rear)	injury		Yes 2 □ No				
Division of	I or Attendate death Director:	Certification: To	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide detern	_: 28e, Plat	ce of Injury - At ho ding, etc. (Specif	ome, farm, st	eet, factory, office		28f. Location (S City or Tow	treet and Numb n, State)	er or Rura	I Route Number,
	vital ours af ral Di											
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Medical		Examiner: On the			h occurred at the tin exestigation, in my o					
	To th To th Comp	Me	29b. Signature and title of certific	3//	21	)	29c. License	number	2	9d. Date signe	d (Month,	Day, Year)
	5	ž.	MA	1			1	1013	XUT.	121	38	200
		-	30. Name and address of person	who completed ce	use of death (Item	n 23a) (Type,	Print)	000	GA.	Noc	26	Tronue
	Sta		31. Date filed (Month, Day, Year)	2008	Registrar's Signa	iture	actify	1 vorce	TIME	11000	1 1	200(2
	Registr	ali	DEO OT	LUUU L	JESE JO	A CONTRACTOR	Control of the Contro					

		1 - For State Registrar  1. Decedent's Name (First, Middle, Last)		•	ertificate of		2. Date of Dea	Reg. No. 2		4 3 4 1 3. Time of Death
Physicia /Medic Examin	al	Willard C. Van  4a. Facility Name (If not institution, give and the state of the st			4b. City, Town, o	r Location of Deat	Decembe	4c. Count	2008 ty of Death derick	12:30 A.M
Funeral Director		5. Social Security Number 6. Sex 216-38-0042		(In yrs, last birthda 86 Yrs	ay) If Under 1 Year Months Days			th y, Year)	9. Birthp	place (State or Foreig ntry) yland
Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Exercitive rough be natified at once.	ector	Usual Residence of Decedent  10a. State  10b. County  Maryland  Frederic		10c. City, Town or Frederic				10g. Citizen of		1
s 23a or 2 ust ben	Funeral Director	10e. Street and Number 7623 Sundays Lane	12. Was Decedent Ev		21702	Jianania Ovigina (	English Van ar Na	USA	ace - Americ	
ral", or item Eren ince	þ	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:	)	3. Was Decedent of H If Yes, specify Cub. 1 ☐ Yes ※XXNo		rto Rican, etc.)		ack, White, e	etc.
iene. • than "natui • the the disol	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e co <i>mpleted)</i> College (1-4or 5+	) (G	ecedent's Usual Occupive kind of work done e. DO NOT use retired	during most of wo d)	orking	16b. Kind of E		ssing Co.
Mental Hyg arked other atic event, I	To Be C	17. Father's Name (First, Middle, Last)  James R. VanSant		•		18. Mother's Na Bessie (	me (First, Middle, G. Roderi	Maiden Suma Lck	ame)	
ealth and n 27 is m er traum		19a. Informant's Name/Relationship (Ty Jean VanSant – wif	,	762			Frederic	k, Mary	1and	21702
tment of H tant: If iter ijury or oth		20a. Method of Disposition  1 □ StBurial 2 □ Cremation 3 □ F  4 □ Donation 5 □ Other (Specify)		20b. Place of Di cemetery, Resthav	sposition (Name of crematory or other play ren Memoria	1 29,	2008		ck, Ma	aryland
Depar Impor any In once.		21. Signature of Funeral Service Licens	e de		22. Name and Address 1621 Oposs		Stauffer Pike, Fre			e y1and 2170
nysician Medical xaminer		23a. Part 1. Enter the disease, of compl shock, or heart failure. Elet only of Immediate Cause (Final disease or condition resulting in death)	PITU	he death. Do not of the death.		ng, such as cardia	ac or respiratory a	rrest,		Approximate Interval Between Onset and Death
g physician and as the burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	o	consequence of):						
attending for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at 9 Unknown	Fetal death	3 ☐ Ectopic pregnand 5 ☐ Other (specify)	су			ate of delive	rery Day Year
r death.  ector. After this certificate has been signed by the attendit by the funeral director, page 2 should be detached for use	by	Part II. Other significant conditions co.	ntributing to death but	not resulting in th	e underlying cause giv	ven in Part I.		obacco use co		the cause of death?
has le 2	Completed						24a. Was autoj perfo	an 24b psy prmed2 2 No	D. Were auto prior to co death? 1 ☐ Yes	opsy findings available ompletion of cause of 2 No
certificate rector, pag	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:		Ott	- 0 -	eath (Check only o			
n. After this certifi funeral director,	on: To	1  Yes 2  No '  27. Manner of Death 1  Natural 5  Pending	28a. Date of Injury (Month, Day,	t 2 ☐ ER/Outpa y 28b. Tim Year) Inju	e of 28c. Inju		Home 5 Resi			<u>(y)</u>
after deaun.  Director: Ai  In by the fu	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined				]Yes 2□No	28f. Location ( City or To		nber or Rura	al Route Number,
within 24 hours after deati  To the Funeral Director: completely filled in by the	Medical Ce	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best o iner: On the basis of and manner stat	examination and/	leath occurred at the tor investigation, in my	ime, date and plac opinion, death occ	ce, and due to the curred at the time,	cause(s) and date and place	manner as s	stated. to the cause(s)
To th	Me	29b. Signature and title of certifier	n mo		29c. Licen:	se number 19 <b>3</b> 6		29d. Date sign	red (Month,	Day, Year) <b>2068</b>
(8)		30. Name and address of person who co	ND 450	THOMA	( 10#m 20	N De	FREDE	RICK	MO	21702
Sta Registr		31. Date filed (Month, Day, Year)	32 Registra	r's Signature	hack o					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

State of Maryland / Department of Health and Mental Hygiene, for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2008 Рм 4:30 December Dorothy Lavone Vetter /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Crofton Convalescent & Rehab Center Crofton Anne Arundel If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) Social Security Number **Funeral** 1 □ M 2 XF Months Davs Hours Min. June 9, 87 1921 Nebraska Director 127-07-0074 Usual Residence of Decedent 10d. Inside City Limits 10a State 10h County 10c City Town or Location 28a-f show 7 Is marked other than "natural", or items 23a or 28a-f shov traumatic event, I'm Modical Examinar is usa bond the dat 1X Yes 2 □ No Director Maryland Anne Arundel Crofton 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number with 21114 USA Funeral 2225 E. Defense Highway 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No 14. Race - American Indian. Black, White, etc. within 72 hours after 1 Tes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify. Specify: à 3 XWidowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) filed withir Hygiene. Food Service Waitress alth and Mental Hv. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Emma Henderson ပ Unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any Injury or other trau 12319 Stonehaven Lane Bowie, MD 20715 Suzette Pamela Vetter/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 12/17/2008 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician coronery disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Atherosclero Sequentially list conditions, and the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) the q | Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ derease cerebrovasevlar 1 Yes 2 No 3 Probably 4 Unknown icate has been si , page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an autopsy performed? certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Other: AXXNursing Home 5 | Residence 6 | Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral c 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred I or Attending Patter death.

Director: After 1 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 24 hours a Hospital 29a. Certifier 1 🖰 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 14300 Gallert For Come #100 BOWIE, MD Muss. Ecchery DEC 2 2 2008 32. Registrar's Signature Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Marvland / Department of Health and Mental Hy

		1 - State Registrar		rtificate of		,	_	2008	4341
Physic	ian	Decedent's Name (First, Middle, Last)				2. Date of De Month	ath		3. Time of Death
/Medi	cal	JAMES HAROLD VAN PELT				DECEMB:	ER 2	4, 2008	11:59 P
Exami	ner	4a. Facility Name (If not institution, give street and number)			or Location of Dear	th	4c.	County of Dea	th
Funeral		1916 CHURCHHILL LANE 5. Social Security Number 6. Sex 7. Age (In yrs.)	last hirthday	CHEST If Under 1 Year				QUEEN AI	
Director	ı.	235-72-1107 1X M 2□F 63	Yrs.	Months Days	Hours Min.	(Month, Da	y, Year)	9. Bir	thplace (State or Foreignuntry)
p ,		Usual Residence of Decedent				JULY 5,	194	D ME21	VIRGINIA
anyla shov	5		y, Town or Lo	cation					10d. Inside City Limits
the M	Director		CHESTER	R					1 □ Yes 2 <b>X</b> No
with la or		10e. Street and Number  1916 CHURCHHILL LANE		10f. Zip Code			10g. Citiz	zen of What Co	untry?
death ms 2%	Funeral	11. Marital Status 12. Was Decedent Ever in U.S	2 100	21619				TED STA	ATES
or Ite		Armed Forces?	i i	Vas Decedent of H f Yes, specify Cuba	an, Mexican, Puerl	pecify Yes or No- o Rican, etc.)	1	<ol> <li>Race - Ame Black, White</li> </ol>	
s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. I fleating the marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Extinuor must be redilled at	d by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates: 1968—1	.971	□Yes 2 <b>X</b> No	Specify:			Specify: WH	ITE
natu	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	ent's Usual Occup	ation	trin a	16b. Kin	nd of Business/	ndustry
d within 72 hours aft giene. er than "natural", or the Medical Exercit	dmo	Elementary/Secondary (0-12) College (1-4or 5+)	life. L	OO NOT use retired	1)	KING			
filed Hygi		17. Father's Name (First, Middle, Last)		ENGINE				VESTING	HOUSE
d 2 should be file th and Mental Hy 7 Is marked othe traumatic event,	To Be	JAMES ROY VAN PELT			18. Mother's Nan		Maiden S	Surname)	
should and Men s marke umatic	-	19a. Informant's Name/Relationship (Type. Print)	19h Mailine	Address (Street		EA BARB			
and 2 ealth a n 27 Is		JAMES VAN PELT/SON		Address (Street a					
		20a. Method of Disposition 20b. Pl	ace of Dispos	ition (Name of atory or other place		D .		cation - City or T	
permit. Pages Department of Important: If its any injury or o				atory or other plac E CREMATI	i	IBER 30			
epart epart port y inj		21. Signature of Funeral Service Licensee				08 S	TEVE	ENSVILLE	E, MARYLAND
88 5 8		I he M. Fifth		OO DIMITING	OUR RURD	COLOIL	K M/	FUNERA ARYLAND	L HOME P. A
		23a. Part . Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.	Do not ente	r the mode of dyin	g, such as cardiac	or respiratory arr	est,		Approximate
Physician	ļ	Immediate Cause (Final disease or condition	( )	lon (	anu				Interval Between Onset and Death
/Medical Examiner		resulting in death)  Due to (or as a conseque			-004				24.
	<u>_</u>	Sequentially list conditions, b.							
uted	듣	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ence of):						
execunand and all-tra	Examine	that initiated events resulting in death) Last C	nce of):						
ertificate be executed Jing physician and e as the burial-transit									
rtifica ng phy as th	Medical	O							
eath certificate be executed attending physician and for use as the burial-transit		IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnance					22	od Data of data	
The law requires that the death cate has been signed by the attencage 2 should be detached for us	Physician	in the past 12 months?  1 ☐ Live birth 2 ☐ Fetal of 4 ☐ Pregnant at time of dea		Ectopic pregnancy Other (specify)			23	3d. Date of deliv Month	ery Day Year
ires that the de signed by the	١	9 ☐ Unknown 9 ☐ Unknown							
signer be d	_ ব	Part II. Other significant conditions contributing to death but not resulti	ing in the und	erlying cause giver	n in Part I.	23e. Did tob	acco use	e contribute to t	he cause of death?
w requir	) ted					1 <b>2</b> 1	s 2 🗌	No 3 ☐ Prot	pably 4 ☐ Unknown
e law	Completed					24a. Was ar		24b. Were auto	psy findings available
certificate ha						autopsy perform 1 🗆 Yes 2	ied?	prior to co death? 1 □ Yes	mpletion of cause of
		25. Was case referred to medical examiner?			26. Place of Death			10163	2 🗆 140
Phys r this ral dir	2	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ EF  27. Manner of Death 28a. Date of Injury 2:			4 LI Nursing Ho	me 5 eside	nce 6	Other (Specif	(y)
th. Afte		Natural 5 Pending (Month, Day, Year)	8b. Time of Injury	28c. Injury : Work?		28d. Describe hou	v injury o	occurred	
Atter r dear sctor	2	3 Suicide 6 Could not be	a farm stroot		es 2 No				
ital or Attending P	2	4 Homicide determined 28e. Place of Injury - At home building, etc. (Specify)	s, iaiii, street	, lactory, office	1	28f. Location (Str. City or Town,	eet and N State)	Number or Rura	I Route Number,
ospit hour unera ly fille		29a. Certifier  (Check only  Medical Examiner: On the basis of examination	edge, death o	ccurred at the time	e, date and place	and due to the ca	uso(s) or	nd manner on a	*****
To the Hospital or Attending Phys within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral director.		and manner stated.	n and/or inves	stigation, in my opi	nion, death occurr	ed at the time, da	te and pla	ace, and due to	the cause(s)
To t Com	2	29b. Signature and title of certifier		29c. License r		r 29	d. Date s	signed (Month, I	Day, Year)
118		> 12/ 1 January		()	3793	7	12/	25/21	JOV
47 ns	3	10. Name and address of person who completed cause of death (Item 23	Ba) (Type, Pri	nt) \	3793	CD. 1.	M	1 111	. 0
11/1		Date filed (Month Day Vand		han	In me	NIN	0 - (	~ d/(	uy
State Registrar		11. Date filed (Month, Day, Year) 32. Registrar's Signature							
MH 17 Rev 1/200		DEC 3 0 2008 Janua	9. 100	ake					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1 Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** are /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Annael (1)cd+Unty Medical Anne Centr If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs, last birthday) **Funeral** Months Hours Days 1 □ M 2 🕱 F 82 219-20-8083 01.1926 Director Dec. Pennsylvania Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 10h. County d other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at Arnold Anne Arundel MD 1 ☐Yes 27 No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21012 486 Manor Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 📉 No White Specify: þ 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Office Manager Insurance Companies 11 permit. Pages 1 and 2 should be filed 1 Department of Health and Mental Hygin Important; If item 27 Is marked other 1 any injury or other traumatic event, III 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Theresa C. Gottschalk Walter I. Stickler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Robert H. Willen/ Husband 486 Manor Road Arnold, MD 21012 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Dec. 30 2008 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland Druid Ridge Cemetery 21. Signature of Funeral Service Licenses Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) tending physician a Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 Other (specify) P.O. 1 signed by the a d be detached for 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, ≥ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No cate has I page 2 s certificate 1 □ Yes 1 ☐ Yes Physician; 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital 1 Yes 2 No 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 28a. Date of Injury (Month, Day, Year) 28h Time of 28d. Describe how injury occurred Certification: 27. Manner of Death 28c. Injury at Work? Division Hospital or Attending 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Re Sute 300 Annapolo 900 Bestale

DHMH 17 Rev 1/2001

State Registrar 32. Registrar's Signature

			1 - State Registrar	e of Maryland		artment of F rtificate of I			# 61 F3 F	1.21.17
			Registrar  1. Decedent's Name (First Middle, Last)	•				2. Date of Dea	Reg. No. 2 0 0 8	3. Time of Death
	Physicia /Medic		ELLEN.	$\int_{-i}^{-i}$	W	JOSTE		Month	Day Year	
	Examin	er	4a. Facility Name (If not institution, give street ar	d number)			Location of Deat	n	4c. County of Dea	
-			333 Epping Way 5. Social Security Number 6. Sex	7. Age (In yrs. la	ast hirthday)	Anna	polis If Under 24 Hrs.	8. Date of Birt		e Arundel rthplace (State or Foreign
	Funeral Director		214-46-2473 1□ M 2		Yrs.	Months Days	Hours Min.	8. Date of Birt (Month, Da)	y, Year) C 948 No	ountry) ew York
	D		Usual Residence of Decedent					12/0/1	210	
	arylar show d at	_	10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	he Ma 28a-f otifie	ecto	Maryland Anne Arundel  10e. Street and Number		Annapo	11S 10f. Zip Code			10g. Citizen of What C	
	with with the r	ä	333 Epping Way			· ·	401		USA	ouriu y .
	ms 2%	nera	11 Marital Status 12. Was	Decedent Ever in U.S	3. 13.	Was Decedent of H	ispanic Origin? (S	pecify Yes or No-	14. Race - Am	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, I're I Medical Exeminer must be notified at once.	Completed by Funeral Director	1 Never Married 2 Married 1 1 1 If Yes	ed Forces? Yes 2∭No s, Give r or Dates:		If Yes, specify Cuba 1 □Yes 2 🎇 No	Specify:	o Hican, etc.)	Black, Whi	
5-0	72 ho 'natur	etec	15. Decedent's Education (Specify only highest grade comple	eted)	(Give	dent's Usual Occup kind of work done o	during most of wor	king	16b. Kind of Business	s/Industry
121	vithin	dm	Elementary/Secondary (0-12) Colle	ege (1-4or 5+)		oo not use retired Lee Manage	•		Medica:	1
d 2	illed v Hygic ther t		12th  17. Father's Name (First, Middle, Last)		0111	ce rianage		ne (First, Middle,	Maiden Surname)	J
an	ld be ental ked o	To Be	Willis Eastright				Katl	nryn McL	ardy	
Maryland	shoul and M s mar umat	-	19a. Informant's Name/Relationship (Type. Print	)	19b. Mailir	ng Address (Street	and Number or Ru	ıral Route Numbe	er, City or Town, State,	Zip Code)
Σ,	and 2 salth a n 27 is		Richard D. Wooster/ Se			Ridge Rd		olis, MD	21401	
ore	of He		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal	20b. Pl	ace of Dispo emetery, crer	sition (Name of natory or other plac		Date	20c. Location - City of	
Ë	Enent trant: tant: jury o		4 ☐ Donation 5 ☐ Other (Specify)	Ka Ka		rematory		26/08	Edgewater	
Baltimore,	permit Depar Impor any in		21. Signatur (1974) Service Licensee		2	2973 Solor	mons Isla	and Rd.	Kalas Fune Edgewater,	
			23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause	hat caused the death on each line.	. Do not ent		ig, such as cardia	or respiratory ar	rest,	Approximate Interval Between Onset and Deaths
1	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	ONARIA	M	CA				Onset and Deaths
7	Examiner		Du	ie to (or as a consequ	ence of):					
		Je.	Sequentially list conditions, if any, leading to immediate cauca. Enail Underlying	ie to (or as a consequ	ence of):					
	cuted nd ansit	Examiner	Cause (Disease or injury that initiated events c.							
Ó,	e exe ian ar ırial-tı	Ë		e to (or as a consequ	ence of):					
8760,	icate be executed physician and the burial-transit	dical	d							
Θ			IF FEMALE: 23c. If yes	s, outcome of pregnar	ncv				22d Date of de	Nivon
Вох	leath atter for u	cian	in the past 12 months?	Live birth 2 Petal Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)	У		23d. Date of de Month	Day Year
P.O.	t the c by the achec	Physician/M	9 Unknown 9 U	Unknown						
	The law requires that the death certif ate has been signed by the attending page 2 should be detached for use as	by P	Part II. Other significant conditions contributing	to death but not resu	lting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use contribute t	to the cause of death?
brd	law require as been si 2 should t	ted						1 🗆 Y	es 2 No 3 ☐ F	Probably 4 Unknown
ec	e 2 sh	Completed						24a. Was autop	sy prior to	utopsy findings available completion of cause of
Vital Records,								perfor 1 ☐ Yes	med? death? 2∠ No 1 ☐ Ye	s 2 No
Z:	Physician: r this certific ral director, p	Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No Hospital:	4.5.1		Othe	or.	th (Check only of		
of	ding Physician: n. After this certific funeral director,	μ̈́	27. Manner of Death 28a.		28b. Time of	28c. Injur	y at		lence 6 ☐ Other (Sp low injury occurred	ecity)
ion	inding Fath. r: After ie funeri	atio	1 Natural 5 Pending 2 Accident investigation	(Month, Day, Year)	Injury	M 1 □	<br Yes 2 □No			
Division of	l or Attend after death Director:	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined 28e. I	Place of Injury - At horbuilding, etc. (Specify	me, farm, str	eet, factory, office		28f. Location (S City or Tow	Street and Number or F	Rural Route Number,
	oital ours af									
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funeral process.	Medical	29a. Certifier 1 Certifying Physician: 7 (Check only one) Medical Examiner: On and							
	To the within To the comp	ž	295. Signature and title of certifier	P. A. u	N	29c. Licenso	v/V2C	/	29d. Date signed (Mon	th, Day, Year)
			M Name and address of the state of the	naueo of doeth /lt-	22a\ /T	P. 1	170		1	M -
0	410		MICHAEL J. LOTON	cause of death (Item  32. Registrar's Signat	448	UFFENS	E MG	HWAY	HNNAPO	43MD21401
	Sta Registr		DEC 2 9 2008	Denewa	B. 4	parked				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring Prince George's Renaissance Gardens If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Dec 3, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1∭ M 2□ F Yrs Director 488-36-1524 91 1917 China Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a, State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylai Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at Yas 2 No Director Rockville Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20852 USA 1371 Templeton Place Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Asian 1 ☐ Yes 2X No Specify. þ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) <u>Metallurgical Engineer</u> Research 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be Gitzi Tso Sze Wang Ching Tze 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1371 Templeton Place Rockville, MD 20852 Joseph C. Y. Wang/son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) W. Arundel Crematory 12/30/08 Odenton, MD 21. Signature of Funeral Service Licensee Going Home Cremation Service P.O. Box 784 eyelle M01251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) a Alzheimer's Disease /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): law requires that the death certificate be executed Exami burial-trar Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical the ası for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ≥ Diabetes Mellitus with Neuropathy 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown After this certificate has been s funeral director, page 2 should it Completed Coronary Artery Disease 24b. Were autopsy findings avallable prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 \ No Gastroesophageal Reflux Disease 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Attending 1X Natural 5 Pending To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A completely filled in by the fu al or Attendi s after death. r death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

10

State Registrar Rachelle M. Alexion

31. Date filed (Month, Day, Year)

Silver Spring.

Tachelle M Collegion Mo

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Ri gistrar's Signature

		State of Maryland / De	partment of Health ertificate of Death		ygiene Reg. No. 2008 43419
		Decedent's Name (First, Middle, Last)		2. Date of D	leath 3. Time of Death
Physicia /Medica		Lillian A. White		Decemb	per 19 2008 6:55 P M
Examine		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location	of Death	4c. County of Death
r		Genesis Elder Care @ Spa Cree			Anne Arundel
Funeral Director		5. Social Security Number $6. \text{ Sex}$ 7. Age (In yrs. last birthof $213-26-1467$ $1 \square \text{ M} 2 \ \text{X} \text{ F}$ 87 Yrs	Months Days Hours	Min. Oct 2	9. Birthplace (State or Foreign Country) Maryland
		Usual Residence of Decedent			
arylan show	_	10a. State 10b. County 10c. City, Town of			10d. Inside City Limits 1 □Yes 2☑ No
he Ma	Directo	Maryland Anne Arundel Arnol	10f. Zip Code		10g. Citizen of What Country?
with t	直	833 Clifton Ave	21012		USA
death ms 2:	Funeral		3. Was Decedent of Hispanic O If Yes, specify Cuban, Mexica	Origin? (Specify Yes or N	
after or ite		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give	1 Yes 2 No Specify		
3-003	od by	3 ¥ Widowed 4 □ Divorced Year or Dates:	cedent's Usual Occupation		Specify: Black  16b. Kind of Business/Industry
in 72 in 72 in mat	plete	(Specify only highest grade completed) (G	ive kind of work done during mo e. DO NOT use retired)	ost of working	loo. And of Business/maustry
d with giene er tha	Completed	Elementary/Secondary (0-12) College (1-4or 5+) 7 College (1-4or 5+) 0	Presser		Cleaner's
Idina Id be file lental Hy Ked oth Ic event,	Be (	17. Father's Name (First, Middle, Last)		her's Name (First, Midda	le, Maiden Surname)
atytatio Z 1 Z 1 3-0030 should be filed within 72 hours after death with the Maryland and Mental Hygiene. s marked other than "natural", or items 23a or 28a-f show umatic event, it a Medical Expiritive must be notified at	၉	William A. Evans		ace Hall	the Chartest Chartest To Oak
Mich d2st d2st tth and ttraun traun					nber, City or Town, State, Zip Code)
s 1 an f Heal item 2			Clifton Ave	Date Date	Md . 21012 20c. Location - City or Town, State
antification mail: Pages partment of portant; If it portant; If it y y injury or o				12-24-08	Annapolis, Md.
DEMINITION FOR INTERNITY AND A TAIN SOURCE STEEL SHOUS OF PRINCE AND A STREET HER WARNAN DEPARTMENT OF HEALTH AND MENTAL Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, It is Micrical Experiment to incline any once.		21. Signature of Funeral Service Licensee	MMName Preventer of Eaci		_
		garry S. Jeen MCC 183	821 West St.	~	
	. U	23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause of act line.	•	as cardiac or respiratory	arrest, Approximate Interval Between Onset and Death
Physician /Medical		resulting in death)	1 a		1 weer
Examiner		Due to (or as a consequence of):			
	ner	Sequentially list conditions, if any, leading to immediate taute. Enter the Jarryh g Cause (Disease or injury			
ecuted and transi	Examiner	that initiated events c.			
icate be executed physician and the burial-transit	Ē	resulting in death) Last Due to (or as a consequence of):			
ificate g phys	edical	d			
ath certi	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	0 🗆 🗖 🗖		23d. Date of delivery
death	sicia	in the past 12 months?  1  Yes 2 No  1  Yes 2 No	3 ☐ Ectopic pregnancy 5 ☐ Other <i>(specify)</i>		Month Day Year
at the	Phy	9 Li Unknown		al 220 Die	tobacco use contribute to the cause of death?
ires the signeral signeral labe d	ğ	Part II. Other significant conditions contributing to death but not resulting in the	a undenying cause given in Fart		Yes 2 No 3 Probably 4 Unknown
law requires as been sign 2 should be	Completed		<del>-</del> -	24a. Wa	
he lav e has	dmo			aut	opsy prior to completion of cause of death?
VICAL ician; T certificat ector, ps	a	25. Was case referred to medical	26. Plac	1 ☐ Yes	
ysici nis cel	To B	examiner? 1  Yes 2 No Hospital: 1 Inpatient 2 ER/Outpa	tient 3 DOA Other: 4 N	Nursing Home 5 ☐ Re	sidence 6 ☐ Other (Specify)
In O	.iio	27. Manner of Death 1 Date of Injury 28a. Date of Injury (Month, Day, Year) 28b. Tim (Month, Day, Year)	y Work?		e how injury occurred
ttendi death.	icati	2 Accident investigation	M 1 □Yes 2 □		Ctract and Number or Dural Pouts Number
I or Attending Phy after death. Director: After this d in by the funeral c	Certification;	4 Homicide determined 28e. Place of Injury - At home, farm building, etc. (Specify)	street, factory, office	City or T	(Street and Number or Rural Route Number, own, State)
ita Isan		29a. Certifier Sertifying Physician: To the best of my knowledge, c			
the Ho	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/cone) and manner stated.	r investigation, in my opinion, de	eath occurred at the tim	e, date and place, and due to the cause(s)
To T	2	29b. Signature and title of certifier	29c. License number	10571	29d. Date signed (Month, Day, Year)
May		Many VI 11	000	27/ //	1424200
, Day		30. Name and address of person who completed cause of death (llem 23a) (Ty	25E Det	ense t	try, Crotton and
Stat Registra		31. Date filed (Month Par 2a) 2008 32 Registrar's Signature	parked		

DHMH 17 Rev 1/2001

Physicia /Medic Examin

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Evan, fror must be notified a once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

daw	4
	Sta

	-	State Registrar			,	Ce	ertificat	e of Death	7	Re	g. No. 2 0	108	434	20
ysicia	2	1. Decedent's Name (Firs	t, Middle, Las	*						2. Date of Death Month	Day	Year	3. Time of D	eath
dic				Florer	nce J. V	Vills	1			December	26, 2	800	3:00 A.	М
mine	er	4a. Facility Name (If not in	nstitution, give	e street and num	ber)			Town, or Location	of Death			y of Death		
		470 West Dare					-	e Frederick	- 04 [[		Calvert			
ral		5. Social Security Number		ex □ M 2 🗹 F   7	'. Age (In yrs. la		) If Under Months	Days Hours	Min.	8. Date of Birth (Month, Day,		Coun	ace (State or i try)	Foreign
tor	-	053-32-7811 Usual Residence of Dece	dent			83 <sup>Yrs.</sup>				November	8, 1925	D.C.		
es.	- 1		County		10c. City	, Town or L	ocation					10	d. Inside City	Limits
once.	ğ	MD C	alvert		Princ	ce Fred	erick						1 ☐ Yes 2	No
	Director	10e. Street and Number					10f. Zip	Code		10	g. Citizen of	What Count	try?	
		470 Most Dara	o Doooh	Dood Ant +	1206			20678	•					
	Funeral	470 West Dare	es Deacii	12. Was Deced	lent Ever in U.S	6. 13	. Was Deced	ent of Hispanic O ify Cuban, Mexica				ce - America		
		1 Never Married 2	Married	Armed Ford	2 [X]No					Hican, etc.)		ack, White, e	tc.	
	þ	3 ☑ Widowed 4 ☐ D	Divorced	If Yes, Give Year or Da			1 ☐ Yes 2	No Specify Specify	у:		Speci	fy: Bla	ack	
8	Completed		Decedent's Ed	lucation de completed)		16a. Dec	edent's Usua e kind of wor	l Occupation k done during mo	ost of workin	1	6b. Kind of E	Business/Ind	ustry	
	ğ	Elementary/Secondary		College (1-	4or 5+)		DO NOT us							
	౭ె	7				Don	nestic	1		45° - 4 . N. A.			Ise's Hom	ie
	Be	17. Father's Name (First,	Middle, Last)					18. Moth	ners Name	(First, Middle, M	aiden Surnai	me)		
	၉			Jones						arl Hicks				
		19a, Informant's Name/R		Type. Print)						I Route Number,	City or Town	n, State, Zip	Code)	
	ŀ	Ilean Ray - Sis			20h Pi		D. Box 37 osition (Nan	6, Owings, I		Oc. Location	- City or To	wn State		
		1 ☑ Burial 2 ☐ Crei	mation 3 🗆		00	emetery, cri	ematory or o	her place)		2	OC. LOCATION	- Oity Of TO	wii, Glate	
		4 □ Donation 5 □ C			Mt. I			Cemetery		09 9	Sunderla	nd, MD		
anice		21. Signature of Funeral Stadup		Lewell				d Address of Faci	•					
		23a. Part 1. Enter the disc			used the death					Dares Beac		nce Frede	Approximate	20678
ı		shock, or heart failu		one cause on ea	ch line.								Interval Betwee	
n		Immediate Cause (Final disease or condition resulting in death)	_	и			LRONI	OSSTE	UCTIL	F pulm	SNART	1 201	ME -	YFA
il r		resulting in security		Due to (o	r as a consequ	ence of):								
	<u>.</u>	Sequentially list condition if any, leading to immedia	ns,	b. — Due to (c	r as a consequ	ence of):								
	ir Li	Cause (Disease or injury	**************************************	200.00	. ao a conocqu	01.00 0.,1								
	Examiner	that initiated events resulting in death) Last		C. Due to (c	r as a consequ	ence of):								
			·	d										
	Medical			· · ·										
		IF FEMALE: 23b. Was decedent pregr		23c. If yes, outc		ncy	□ Fetonia n	e en on ou			23d. Da	ate of delive	ry	
	Physician	in the past 12 month 1 ☐ Yes 2 ☑ No	ns?	4 🗌 Pregna	rth 2 ☐ Fetal ant at time of de		☐ Ectopic p ☐ Other (sp				M	lonth	Day Ye	ar
	hys	9 Unknown		9 Unkno	WII									
	S P	Part II. Other significant				-	underlying c	7	-	23e. Did toba	/	ntribute to th	e cause of dea	ath?
	ed	HYPERTER	5137	CURO	NART	A	CTERA	DIJEA	36	1 346	2 🗆 No	3 Prob	ably 4 ☐ Un	known
	Completed by									24a. Was an autopsy	24b.	Were autop	sy findings av	ailable
	E									perform		death? 1 ☐ Yes		100 01
	Be	25. Was case referred to	medical					26. Plac	ce of Death	(Check only one				
	၉	examiner? 1 ☐ Yes 2 ☑ ¥6		Hospital: 1 ☐ In	patient 2 🗆 I	ER/Outpation	ent 3 DC	Other: 4 🗆 N	Nursing Hor	me 5 Resider	nce 6 □Ot	her (Specify	')	
	ü	27. Manner of Death 1 ☑ Natural 5 □	Pending	28a. Date o	f Injury , <i>Day, Year)</i>	28b. Time Injury	of 2	Bc. Injury at Work?	2	28d. Describe how	v injury occu	rred		
	satic	2 Accident	investigation				М	1 □ Yes 2 □	□No					
	Certification:	3 ☐ Suicide 6 ☐ 4 ☐ Homicide	Could not be determined	Zoe. Place (	of Injury - At hor g, etc. <i>(Specify</i>	me, farm, s	treet, factory	office	2	28f. Location (Str. City or Town,	eet and Num State)	ber or Rurai	Route Numbe	9Γ,
	ව													
	ical	(Check only 2 1	Certifying Ph Medical Exan	niner: On the ba	sis of examinat	vledge, dea ion and/or	ath occurred investigation	at the time, date a in my opinion, de	and place, eath occurr	and due to the ca ed at the time, da	use(s) and n te and place	nanner as st , and due to	ated. the cause(s)	
	Medical	one)	f certifier	and mann	er stated.		200	. License number	r	20	d Date sign	ed (Month 1	Day Yearl	
	-	29b. Signature and title of certifier						29c. License number  29d. Date signed (Month, Day, Year)  DFC F 1/3 F 29, 20						
	-	(phu	CT Sh	2gol	us	20-1-1-								
		30. Name and address of	person who	completed cause	1	23a) (Type	e, Print) 	1.1.5	ELE	DERIC	1-	m)	-211	20
101			y, Year)	32. Re	gistrar Signat	ure	1	(NUC	( ) - (	9. 3.0	~ ( (		06	10
Stat istra	ir	31. Date filed (Month, Day	DEC 3	1 2008	10		Ros	. M. O.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day George Henry Watson December 25, 2008 2010 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Hospital St. Mary's Leonardtown 7. Age (In yrs. last birthday)
76 Yrs. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) Days Hours 1**X** M 2 □ F 577-44-1419 Oct 12, 1932 Washington, Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No MD Calvert Huntingtown 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 600 Small Reward Road 20939 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 No 3₺ Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cartographer Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Watson Irene 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8590 St. Andrews Drive Chesapeake Beach, MD Donna Brooks (daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lee Crematory 2008 Clinton, MD 22. Name and Address of Facility Lee Funeral Home Calvert, PA 21. Signature of Funeral Service Licensee Cary J. Goff 8125 Southern Maryland Blvd. Owings, MD 20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only Immediate Cause (Final diseese or condition resulting in death) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 ₩hknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No. 24a. Was an 1 □Yes 2 1

**Physician** /Medicat Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

**Director** 

r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at

other

S Health em 27 i

other

permit. Pages 1 and Department of Heah Important: If item 2 any injury or other once.

Pages 1 and 2 should be nent of Health and Mental

Director

Funeral

Completed by

Be

ပ္

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Examiner Physician/Medical

attending physician and for use as the burial-transit certificate funeral director. After this

P.O.

Physician: The law requires that the death certificate be executed Be Completed by Vital Certification: To of Hospital or Attending within 24 hours after death. filled in by Medical

completely State Registrar

29b. Signature

Manoj D.

31. Date filed (Month, Day, Year)

s of person

Panwala,

0

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA 27. Man of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Modical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

Leonardtown, MD

29d. Date signed (Month, Day, Year)

-2008

DHMH 17 Rev 1/2001

25500 Pt. Lookout Road

who completed cause of death (Item 23a) (Type, Print)

32. Registra Signature

MD

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 12 **Physician** 23 68 0753 AM Roger Martin Williams, Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** WMHS-Braddock Campus Cumberland Allegany If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 9. Birthplace (State or Foreign Country) Maryland 7. Age (In vrs. last birthdav) **Funeral** 1 X M 2 □ F Days 219-52-1162 60 May 03, 1948 Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits show Department of Health and Mental Hygiene. Important; or items 23a or 28a-f show important; if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinational Lagrantical at once. Director 1 ☐ Yes 2 No Maryland Allegany Frostburg the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19410 Old Dan's Rock Road 21532 Funeral death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 □Yes 2 No Specify δ Specify: 3 Widowed 4 Divorced White Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Maintenance 12 University 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Williams 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna Williams - Wife 19410 Old Dan's Rock Road, Frostburg, Maryland, 21532 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) December December 20c. Location - City or Town, State 1 ☐ Burial 2 MCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cumberland Crematory Cumberland, Maryland 29, 2008 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eichhorn-McKenzie Funeral Home P.A. 8 East Main Street Lonaconing, MD 21539 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final Physician PSI S disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a 1 Tyes 2 No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? è Neck Cancer s been significant 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy The perform 1 ☐Yes 2 ☐ No 1 □Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 12 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

P.O. Box 68760, Division of Vital Records, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

Saltimore, Maryland 21215-0036

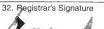
Certification: To Medical 29b. Signature and title of certified

State Registrar

31. Date filed (Month, Day, Year) JAN

30. Name and address of person wild completed cause of death (Item 23a) (Type, Print)

625



Kent Avenue

Dr. Sunil Gupta

(Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

20033280

Cumberland, Maryland 21502

29d. Date signed (Month, Day, Year) Dec 29 200 8

			1 - For State Registrar	State of Marylar		artment of H rtificate of L			giene 0	80	43423	
	Physici	20	Decedent's Name (First, Middle, La	-					ath Day	Year	3. Time of Death	
	/Medic			ean Wene	gara	L		Month 12	25	08	1010 M	
	Examir	ier	4a. Facility Name (If not institution, giv		1		Location of Death		4c. County		4.1	
			5. Social Security Number 6. S	Jernany Robert T. Ago (In yrs.	last highday	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt		rre		
	Funeral Director			DIM ONE	76 Yrs.	Months Days	Hours Min.	Feb. 20	v. Year)	9. Birthp Cour	lace (State or Foreign stry) yland	
			Usual Residence of Decedent		70			I ED. ZC	77 1952	naL	yıand	
	how		10a. State 10b. County	10c. Cit	ty, Town or Lo	ocation			·	1	0d. Inside City Limits	
	8e-1 e	cto	MD Garrett		Grants	/ille					1 ☐ Yes 2 🛣 No	
	vith th	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Cour	itry?	
	e 23e	era	10906 New Germany		6 10	21526			USA			
21215-0036	s 1 and 2 should be filed within 72 hours after deeth with the Maryland thaths and Mental Hygiene. Items 27 is marked other than "naturel", or items 23s or 28s-f show other traumatic event, the Medical Examination in the multiple at	by Funeral	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of Hill If Yes, specify Cubar 1 ☐ Yes 2 1 No		Decity Yes or No- Dican, etc.)	Specif	ce - Ameno ck, White, v:		
ğ	2 hou	ted	15. Decedent's E	ducation	16a. Dece	dent's Usual Occupa	ition		16b. Kind of B			
2	thin 7 en n	Completed	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+)	(Give	kind of work done d DO NOT use retired,	luring most of work )	king			,	
7	filed wil Hygien other th	Con	12		Seams	stress			Textil	extiles		
ng	be file tal Hy d ofth	Be	17. Father's Name (First, Middle, Last,				18. Mother's Nam	e (First, Middle,	Maiden Suman	1e)		
$\frac{8}{2}$	2 should be and Mental is marked caumatic even	T <sub>o</sub>	Roy Mickey				Irva Ash					
Maryland	12 sh h and 7 ie m traum		19a. Informant's Name/Relationship (			ng Address (Street a						
	Health tem 27 i		Logan J. Wengerd			New Gern		Grants	Ville,		1536	
ğ	Pages nent of int: If it		1 ☐ Burial 2 ☑ Cremation 3 ☐	Removal from State	emetery, crer	natory or other place	9)					
altimore,	그 돈 돈 쓸 .		4 ☐ Donation 5 ☐ Other (Specification of Funeral Service Liceration)			Side Crema . Name and Addres		the second second second				
Ba	Depe Impo any is		I De Lyner	Leuman	) P.	O. Box 27	75, Grant	sville,	MD 21	536	r.M.	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	one cause on each line.			g, such as cardiac	or respiratory ari	rest,		Approximate Interval Between	
, ,	Physician		Immediate Cause (Final disease or condition resulting in death)	a Pancr	eati	c (	ance	. ~			Onset and Death  2 Years	
	/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):							
		-	Sequentially list conditions,	b. Due to for as a consequ	unase off							
	nsit	ulu.	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	200 10 (21 40 4 55)1000	201130 01).							
<u>,</u>	cate be executed physician and the burial-transit	Examiner	that initiated events resulting in death) Last	C. Due to (or as a consequ	uence of):							
8760	te be ysicia e bur	dlcal		d.								
9		fed		- 12					177			
O. Box	at the death certifii by the attending I tached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of do 9 ☐ Unknown	Ideath 3□	Ectopic pregnancy Other (specify)			23d. Dai Mo	e of delive nth	ry Day Year	
<u>.                                    </u>	law requires that the as been signed by th 2 should be detache	by Pl	Part II. Other significant conditions of	ontributing to death but not rest	ulting in the ur	nderlying cause give	n in Part I.	23e. Did to	bacco use cont	ribute to th	e cause of death?	
Vital Hecords,	w require been sig should b							1 🗆 Y	es 21 No	3 Proba	ably 4 DUnknown	
ပ္တ	aw requisite been	Completed						24a. Was a		Vere autop	osy findings available	
ř	e h	E O						autops perfori	med?	prior to con leath? Yes	apletion of cause of	
<u>=</u>	ician: T certificet rector, pa	Be	25. Was case referred to medical examiner?				26. Place of Deat			163	20 140	
5	d is	٥	1 ☐ Yes 2 ☐ No	Hospital: 1   Inpatient 2	ER/Outpatien	t 3 DOA Other	r: 4 🗌 Nursing Ho	me 5 Reside	ence 6 Oth	er (Specify	)	
	ding h. After fune	atlon:	27. Manner of Death  1 Natural 5 Pending  2 Accident investigation		28b. Time of Injury Mork?  M 28c. Injury at Work?  1  Yes 2 No							
DIVISION	tal or Atten s after deat al Director: ed in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, stre	eet, factory, office		28f. Location (Si City or Town	reet and Numb n, State)	er or Rural	Route Number,	
	To the Hospital or Al within 24 hours after of To the Funeral Direc completely filled in by	Medical	29a. Certifier (Check only one) 1. Cartifying Ph	ysician: To the best of my knowiner: On the basis of examination and manner stated.	wledge, death tion and/or inv	occurred at the time restigation, in my opi	e, date and place, inion, death occurr	and due to the cred at the time, d	ause(s) and ma ate and place, a	nner as sta and due to	ated. the cause(s)	
	To the within 2 To the complet	ž	29b. Signature and title of certifier		1 ^	29c. License			9d. Date signed			
)			Have Da	Dull June	la De	) H26	154		12/2	61	2008	
		ID	30. Name and address of person who	completed cause of death (Item	23a) (Type,	DH26 Print) RACK		~ \. I	0		71000	
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signal	ture	IC LICK	52 An. C	replai	uck, M	VID.	C1270	
	Registra		JAN - 5 20	109 June	A. 16	med 1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Month Year **Physician** DECEMBER, 28 /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner OSP, TAL CAR STER If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. May 11, May 11 7. Age (In yrs. last birthday) Security Number **Funeral** 1**⊠** M 2□ F NJ 148-14-2415 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Executant Lear of filed at 1X Yes 2 No Director Carroll Westminster MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number within 72 hours after death with 21158 USA 202 St. Mark Way Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Š 3 Widowed 4 Divorced Ye ar or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Journal of Commerce Financial Journalist permit. Pages 1 and 2 should be filed: Department of Health and Mental Hygin Important: If item 27 is marked other any injury or other traumatic event, III 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Hattie Brown Ripley Watson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 202 St. Mark Way Westminster, MD 21158 Barbara Watson/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 12/3072008 1 ☐ Burial 2 Macremation 3 ☐ Removal from State Carroll Cremation, Inc Hampstead, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Sinnature of Funeral Service Ligansee Priviles Purertal Mome and Chapel, P.A. -V 412 Washington Road Westminster, MD 21157 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ME Sequentially list conditions, if a y, leading to in modate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine the death certificate be executed the attending physician and hed for use as the burial-transit Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) n signed by the a Ö □Yes 2□No 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown To the Hospital or Attending Physician. The Markhin 24 hours after death.

To the Funeral Director: After this certificate has been significantly filled in by the funeral director, page 2 should I Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Nopatient 2 ☐ ER/Outpatient 3 ☐ DOA ပ္ 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 29b. Signature and title of certifier ebotoru, M. O 29c. License number 29d. Date signed (Month, Day, Year) WIL 00067271

MIC

State Registrar 31. Date filed (Month, Day, Year)

Registrar

J 15 A

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

MEMORIAL

DEC 3 0

VALERIU CEBOTARU

WEST MINSTER.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** Frank J. Wojcicki PM 2:35 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** BALTIMORE AGNES HOSPITAL If Under 24 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Days Months 1**X** M 2□ F 91 Yrs. 155-12-3536 New Jersey Oct. 02, 1917 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show or items 23a or 28a-f show Catonsville Baltimore 1 ☐ Yes 2 X No Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 719 Maiden Choice Lane, BR 226 USA 21228 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 XI Yes 2 No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ò 1 ☐ Yes 2 📉 No Specify White Specify: ģ traumatic event, the Medical Example 3 Widowed 4 ☐ Divorced natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Defense Contractor Elementary/Secondary (0-12) College (1-4or 5+) Senior Technical Writer Westinghouse 5+ and Mental Hygie Is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frank Wojcicki Mary Kozerefski ္ပ 19a. Informant's Name/Relationship (Type. Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a Elizabeth A. Wojcicki/ in-law 1173 Summit Drive Annapolis, MD 21409 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date UNK 6 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any Injury or once. Crownsville, MD MD Veterans Cemetery 4 Donation 5 Other (Specify) 21. Signature of Fuperal Service Licensee 82. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ASPIRATION HOURS PNELULIONIA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner WEEKS DYSPHAGIA SECONDARY Equantary list our dilicus, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) • Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
• Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-transit SEPTICE MIA WEEKS MRSA Due to (or as a consequence of) Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) P.0. icate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ tebrillation 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No 24a. Was an autopsy 1 ☐ Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□Yes XONo 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Medical 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 24 ho

To the Fune

completely f (Check only one) and manner stated. the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 2008 Gatheana 21 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GATHECHA 990 SCATON AUE BALTIMOREMDI 21229 State Registrar

			For State	State	of Maryla		artment of H		lental Hy	giene 2 N	0.8	43426	
			Registrar  1. Decedent's Name (First, Middle	Last)			tillouto or i	Joann	2. Date of Dea	ath	-	3. Time of Death	
	Physicia	_	Sandra	Lee			Wise		Month	Day er_30,_2	Year	11:48 P M	
4	/Medic Examin		4a. Facility Name (If not institution		ımber)			Location of Death	Decemb	4c. County		11.40 1	
	LAUIIIII	Ç.	702 Lanvale St	•			Hagersto	own		Washi	ngto	n	
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 💢 F	7. Age (In y	rs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	h y, Year)	9. Birthpl Coun	lace (State or Foreign ltry)	
e ado	Director		215-34-4100 Usual Residence of Decedent		70	Yrs.			Mar. 18	3, 1938	Mary	yland	
	and	1	10a. State 10b. County		10c.	City, Town or Lo	cation				10	0d. Inside City Limits	
	Mary -f sho fied a	ţō	MD Washi	neton	F	lagersto	wn					1 X Yes 2 □ No	
	r 28a	Director	10e. Street and Number		1		10f. Zip Code			10g. Citizen of V	Vhat Coun	itry?	
	th wit 23a o Ist be		702 Lanvale St.				21740			ш.	S.A.		
	r dea	Funeral	11. Marital Status	Armed F		1 U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.)		e - America k, White,		
S	s afte	by Fi	1 ☐ Never Married 2 Marri 3 ☐ Widowed 4 ☐ Divorced	ed 1 Tes If Yes, G Year or I	2 X No live		1 ☐ Yes 2 💢 No	Specify:		Specify			
9500-6121	hour tural		15. Decedent		Jales.	I 16a. Dece	dent's Usual Occup	ation		16b. Kind of Bu	Whi usiness/Ind		
Š	in 72 n "na Medic	plet	(Specify only highes	t grade completed)	) (1-4or 5+)	(Give	kind of work done o DO NOT use retired	during most of work i)	king				
	d with giene grene rr tha the l	Completed	Elementary/Secondary (0-12)	College	(1-401 5+)	Unit	Clerk			Medica	1		
9	be filed within 72 hours after death with the Maryland Ital Hygiene. d other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	Be (	17. Father's Name (First, Middle,	Last)				18. Mother's Nam	e (First, Middle,	Maiden Surnan	ie)		
Ma	2 should be and Mental Is marked or aumatic eve	2	Eugene L. Furge					Vivian N					
Maryland 2	ss 1 and 2 should by Health and Ment item 27 Is marked rother traumatic e		19a. Informant's Name/Relationsh Glen E. Wise/Hu				ng Address (Street 5 Harbing			-	State, Zip		
	1 and Health em 27 ither ti		20a. Method of Disposition	- ISDAIIG	201		osition (Name of matory or other place		Date	20c. Location -			
و	Pages nent of I int: If ite		1 🕅 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S <sub>i</sub>		i State		matory or other plac en Cemete	1	/2009_	Hagerst		MD	
Baitimore,	permit. P Departme Importan any Injur	ı	21. Signature of Funeral Service		1.0		2. Name and Addre						
ñ	permit. Pages Department of Important: If it any Injury or once.		& S. Mark	. Sim	•		601 Penns						
8760,	The law requires that the death certificate be executed  We dig a second to the attending physician and bage 2 should be detached for use as the burial-transit	dical Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last	a. Due to	o (or as a cons	se uence of):		inco				Approximate Interval Between Onset and Death	
ROX PR	leath certifica attending ph I for use as tf	an/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	1 ☐ Live	utcome pf pre	etal death 3	Ectopic pregnancy	y			te of delive	ery Day Year	
J. C.	res that the designed by the air	To Be Completed by Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unki			Other (specify) _						
rds, I	w requires this been signed should be de		art II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did t	obacco use cont es 2□ No	use contribute to the cause of death?		
Vital Records,									24a. Was autor perfo	osy ormed2	prior to cor death?	psy findings available mpletion of cause of 2 No	
Z	ician; sertific ector,		25. Was case referred to medical examiner? 26. Place of Death (Check only one)										
	Physical this call directions		1 ☐ Yes No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify)										
O a tage of Death 28a. Date of Injury 28b. Time of Injury 28b. Time of Injury 28b. Injury at Work? 28d. Description 28b. Time of Injury Work? 1 York 2 Not Natural 5 Pending (Month, Day Year) M York 2 Not Natural 5 Pending (Month, Day Year) M York 2 Not Natural 5 Pending (Month, Day Year) M York 2 Not Natural 5 Pending (Month, Day Year) Not Natural 5 Pending (Month, Day Year) Not Natural 5 Pending Natural								Zou. Describe	scribe now injury occurred				
DIVISION OF	i or Attending Ph after death. Director: After th in by the funeral	Medical Certification:	2 Accident investig 3 Suicide 6 Could in 4 Homicide determine	not be 28e. Plac	ce of injury - A ding, etc. (Sp	t home, farm, st ecify)	reet, factory, office		28f. Location (i City or To	Street and Numb wn, State)	er or Rura	al Route Number,	
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director, i		29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  [Check only one]  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
	To the I within 2 to the I complet		29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)										
•			Maria (	lan		Lo MI	7 DH	6473	,	12/2	111	28.	
	411		30. Name and address of person	who completed car	use of death (	0 - 6	Print)	7 11		1		0.141	
0	OH ->	to	31. Date filed (Month, Day, Year)	ndan 32.	egistrar's Si	ignature	MITC C	111	adero	NW @1	W	241140	
4	Regist		JAN 05		enve	B. A	all		7				

**Physician** /Medical Examiner **Funeral** Director and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygiene.

m 27 is marked other than "natural", or items 23a or 28a-f show Examiner must be notified at Director Funeral Baltimore, Maryland 21215-0036 þ Completed permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natur any Injury or other traumatic event, the Medical Be ပ္ **Physician** /Medical Examiner Examiner certificate be executed attending physician and for use as the burial-transit Division or Vital Records, P.O. Box 68760. Physician/Medical be detached for use þ page 2 should Completed certificate has funeral director.

Amended Item 29c per Phy. 12/29/2008 Carroll Co., wil Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 26, 2008 Leonard Leroy Zgorski 2:15 A December 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Carroll County Mampstead 4507 Black Rock Road If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Y Dec. 24 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Pennsylvania Months Days Hours 219-16-9378 1**X** M 2□ F 32 Yrs. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County Maryland Carroll County Hampstead 1 ☐ Yes 2 No 10g. Citizen of What Country? 10f. Zip Code 21074 10e. Street and Number United States 4507 Black Rock Road 12, Was Decedent Ever in U.S Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1954-1 Never Married 2 X Married white 1 ☐ Yes 2 🖾 No Specify: 1958 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) construction construction supervisor 18. Mother's Name (First, Middle, Maiden Surname)
Margaret F. Fckrote 17. Father's Name (First, Middle, Last) Adam Zgorski, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4507 Black Rock Road Hampstead, Maryland 21074 19a. informant's Name/Relationship (Type. Print) Carol Boudreau Zgorski-wife Date 29, 20b. Place of Disposition (Name of cemetery, crematory or other place)

Carroll Cremation 20c. Location - City or Town, State 20a Method of Disposition Dec. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hampstead, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2008 22. Name and Address of Facility 21. Signature of Funeral Service Licens Eline Funeral Home Hampstead, Maryland 21074 934 South Main Street M01072 1 www 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Multiple myeloma disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 Fetal death 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 9□Unknown 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No autopsy performed? Yes 2X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 XNatural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) 2 Medical and manner stated. 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Center St. Westminster Na MD

State Registra

31. Date filed (Month, Day,

200B

DHMH 17 Rev 1/2001

After this

the

completely

To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After

WJZ 6+IVA

State Registrar 31. Date filed (Month, Day, Year) 1. 2008



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001 DEC 3 1 2008

State of Maryland / Department of Health and Mental Hygiene 2 43430 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 9:45 AM Esther Mabel Anderson Dec. 28, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Crescent Cities Nursing Home Riverdale Prince George's 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Days Hours Min. Months Director 218-20-1746 88 March 10, 1920 Pennsylvania Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or items 23a or 28a-f show ary or other traumatic event, the Medical Examinal matter to a citied at 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits Directo Maryland Prince George's 1 X Yes 2 □ No Bladensburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5010 Upshur Street Funeral 20710 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: 夕 If Yes, Give Year or Dates: Specify: White 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) International Office Clerk Assoc. of Machinist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Hundsrucker Krescentia Schimpfhauser 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and:
Department of Health
Important: If item 27
any injury or other tr.
once. Ethel M. Haker / Sister 5010 Upshur Street, Blandensburg, MD 20710 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery 01/02/2009 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Constan Gasch's Funeral Home, P.A. Hyattsville, MD 20781 asen 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** anci homa 1 Reins disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death
☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) the detached 9 Unknown signed be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ≥ HRUNICO US tructive 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed page 2 should menti 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? certificate Division of Vital 1 □Yes 1 ☐ Yes 2 ☐ No Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Hospital or Attending 24 hours after death. 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No hin 24 hours after death the Funeral Director: the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number DECEMBER 28 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4203 QUEENSOUNG Rd HYattsville MD 20781 022 MI) 31. Date filed (Month, Day, Year) 32. Registrar's Signatu 1 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien UU 8 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dec 28. Evelyn Anderson 2008 11:10 PM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Pineview Nursing Home Clinton Prince George's 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Year) Months Min. 1 🗆 M Days Hours 578 22 0878 86 July 1922 Washington DC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2□No Maryland | Prince George's Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8505 Lachine Court 20772 United States Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 □Yes 2 □ N If Yes, GiveXX Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify 3√Widowed 4 □ Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housewife Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Milton Hunter Elizabeth 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harry Robert Anderson (Son) 8021 East Ocotillo Drive, Tucson, Az 85750 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XX Yurial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veterans Cemetery Cheltenham, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d 21. Signature of Funeral Servi Alexandria Ferry Road, Clinton, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death nmediate Cause (Final Mreast Metasta h disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, led ling to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Year Day 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2\times No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 🗌 Suicide 6 ☐ Could not be

**Physician** /Medical Examiner The law requires that the death certificate be executed

**Physician** 

Examiner

**Funeral** 

**Director** 

r than "natural", or items 23a or 28a-f show the Medical Experience must be notified at

7 is marked other traumatic event,

: If item 27

Pages 1 and 2 should be one pent of Health and Mental

Health a tem 27 is

permit. Pages Department of Important: If it any Injury or or

Directo

by Funeral

Completed

Be

ဥ

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records,

Physician:

/Medical

Examiner burial-trar attending physician for use as the buria Physician/Medical cate has been signed by the page 2 should be detached 2 Completed certificate funeral director, Be this Certification: To After the

4 Homicide

(Check only one)

29b. Signature and t

29a. Certifier

Medical

ie Hospital or Attending Pl n 24 hours after death. ie Funeral Director: After t completely filled in by

To the P within 2 To the P

State Registrar

1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
itle of certifier	29c. License number	29d. Date signed (Month, Day, Year)							
		^ / /							

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 🗘 ODS W ILL 0 OKO Hampshire vew Inkoma Avenue

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

31. Date filed (Month Year) 32. Resstrar's Signature

determined

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death

1 - For State Registrar

permit. Pages 1 and  $2\,\mathrm{should}$  be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death

Division of Vital Records, P.O. Box 68760,

	1 - State Registrar	Certificate of Death	Reg. No. 2008 434								
cian	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year 3. Time of D								
lical	4 - Facility Manager (Manager) (1)	4b. City, Town, or Location of Death	DECEMBER 31, 2008 11:19								
iner	ANNE ARUNDEL MEDICAL CENTER	ANNAPOLIS	ANNE ARUNDEL								
1	5. Social Security Number 6. Sex 7. Age (In yrs. last L	Vre Months Days Hours Min.	8. Date of Birth (Month, Day, Year)  9. Birthplace (State or I Country)								
r	Usual Residence of Decedent		DECEMBER 31, 1936 WEST VIRGIN								
-	10a. State 10b. County 10c. City, Town or Location 10d. Inside										
Director	MARYLAND QUEEN ANNE'S CHES		1 □ Yes 2								
ij		10f. Zip Code	10g. Citizen of What Country?								
Funeral	11. Marital Status 12. Was Decedent Ever in U.S.	21619  13. Was Decedent of Hispanic Origin? (Spe	UNITED STATES  ecify Yes or No- 14. Race - American Indian,								
y Fu	Armed Forces? ARMY 1 Never Married 2 Married 1 Never Married 2 Narried 1 Never Married 2 Narried 1 Never Narried 2 Narried 1 Never Narried 2 Narried 1 Never Narried 2 Na	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.) Black, White, etc.								
d by			Specify: WHITE								
Completed	15. Decedent's Education (Specify only highest grade completed)	6a. Decedent's Usual Occupation (Give kind of work done during most of work! life. DO NOT use retired)	ng 16b. Kind of Business/Industry								
mo;	Elementary/Secondary (0-12) College (1-4or 5+)	MASTER SERGEANT	U. S. ARMY								
Be (		18. Mother's Name	(First, Middle, Maiden Surname)								
ဥ	DAVE EDWARD ATKINS, SR.	THELMA									
			al Route Number, City or Town, State, Zip Code)								
	AMELIA ATKINS/WIFE  20a. Method of Disposition 20b. Place	of Disposition (Name of	ESTER, MARYLAND 21619  ate 20c. Location - City or Town, State								
	1	of Disposition (Name of left), crematory of other place) ARLINGTON ONAL CEMETERY 200	RY 13								
To Be Completed by Funeral Director	21. Signature Funeral Service Licensee	22. Name and Address of Facility FELLOWS, HELFENBEIN	AND NEWNAM FUNERAL HOME P								
	106 SHAMROCK ROAD, CHESTER, MARYLAND 21619										
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line.  Approximate Interval Between Onset and Death										
	disease or condition resulting in death)  a. Due to (or as a consequence of):										
	Sequentially list conditions										
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	e of):									
хаш	Cause (Juseuse or Injury that initiated events  c.										
	Due to (or as a consequence of):  d.  IF FEMALE:										
ledic											
		th 3 ☐ Ectopic pregnancy	23d. Date of delivery								
hysician	in the past 12 pronths?  1 ☐ Yes 2 ☐ No 9 ☐ Unknown  1 ☐ Live Dirm 2 ☐ Petal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	5 Other (specify)	Month Day Yea								
<b>Q</b>	OD- Bidah										
d by	Part II) Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of deat								
Completed											
g L			24a. Was an autopsy findings availa prior to completion of cause of death?								
	25. Was case referred to medical	26 Place of Death	1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No								
	examiner?										
lä l	27. Mapper of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred										
atic	1/□ Natural 5 □ Pending (Month, Day, Year)   Injury   Work?   2 □ Accident   Investigation   M   1 □ Yes 2 □ No										
Certification: To	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, for building, etc. (Specify)	arm, street, factory, office	et, factory, office  28f. Location (Street and Number or Rural Route Number, City or Town, State)								
Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge (Check only one) To the basis of examination a and manner stated.	ge, death occurred at the time, date and place, a and/or investigation, in my opinion, death occurre	and due to the cause(s) and manner as stated.  Ed at the time, date and place, and due to the cause(s)								
Mec	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)								
	1601	DEFIET	12/3. De								
-	30. Name and appress of person who completed cause of death (Item 23a)	12/3/18 Mediti									
	Almee To	AIIM	In a propertie								
	31. Date filed (Month, Day, Year) 32 Registrar's Signature	rane 111- act 1/2	OLCOLL CALLE WILLIAMOND								

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2008 For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month RICHARD BUTLER DECEMBER 2008 7:33 P 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death ANNE ARUNDEL HOSPITAL ANNAPOLIS ANNE ARUNDEL 6. Sex 14⊡ M 2□ F Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In vrs. last birthday) Days Hours Min. 578-72-5690 52 MARYLAND 1956 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No PRINCE GEORGE'S BOWIE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 3304 ALYDAR COURT 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black. White, etc. 1 Tyes 2 No ARMY If Yes, Give ARMY Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ZNo Specify: BLACK Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 2YRS Elementary/Secondary (0-12) DIRECTOR GOVERNMENT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) EVELYN MARIE HARLEY RICHARD EDWARD BUTLER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KATHERINE S. BUTLER/WIFE 3304 ALYDAR COURT BOWIE, MARYLAND 20721 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State RESURRECTION CEMETERY 1/5/2009 4 ☐ Donation 5 ☐ Other (Specify) CLINTON, MARYLAND 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 21. Signature of Funeral Servi e Licensee 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Castric > 300 Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Veer 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2√□No 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Spec/fy) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) mh 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Peterson

State Registrar

**Physician** 

/Medical

**Examiner** 

Director

Funeral

Completed

ည

Examiner

Physician/Medical

Be Completed by

Certification; To

Medical

31. Date filed (Month, Day, Year)

DEC 3 1 2008

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event. The Item 25a or 28a-f show any Injury or other traumatic event.

**Physician** 

/Medical

attending physician and for use as the burial-transit

detached

funeral director, page 2 should be

has

this

s after death.

To the Hospital o within 24 hours af To the Funeral Di

filled in by

or Attending Physician: The law requires that the death certificate be executed

P.O. I

Division of Vital Records,

Examiner

Baltimore, Maryland 21215-0036

32. Registrar's Signatu

Certificate of Death

4b. City, Town, or Location of Death

Suitland

# 227

1. Decedent's Name (First, Middle, Last)

5000 Lydianna Lane

Dorothy Garletha Briscoe

4a. Facility Name (If not institution, give street and number,

Physician

/Medical

**Examiner** 

Reg. No. 2. Date of Death 3. Time of Death 26, 2008 1:17 P. M December 4c. County of Death Prince George's 9. Birthplace (State or Foreign Wash., D.C. 10d. Inside City Limits 1y Yes 2 □ No 10g. Citizen of What Country? U.S.A. 14. Race - American Indian, Black, White, etc African-American 16b. Kind of Business/Industry D.C. Government 20747 20c. Location - City or Town, State Washington, D.C. 23d. Date of delivery Year Day 23e. Did tobacco use contribute to the cause of death? 1 X Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 📆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

December 30,2008

State

DEC 3 1 2008 Registrar

29a. Certifier

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

cal



and manner stated

29c. License number

D43276

08-09764 Andre Bland Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2008 43435

		1- For State Registrar	Certifi	cate of I	Death			Reg. No.	200	0 4040
Physicia	an/	Decedent's Name (First, Middle,Last)					2. Date of Month	Day	Year	3. Time of Death
edical Exami	ner	ANDRE	BLAND			P	Decem	ber 27, 20	08	1250 hrs
		4a. Facility Name (If not institution, give st 6543 Pennsylvania Avenue #			. City, Town, or District Heig	ihts		Pri	ounty of Death	e's
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last b	irthday)	If Under 1 Year Months Days	If Under 24H	irs. 8. Date o	f Birth (MM/DD	)/YYYY) 9. Bir Foreid	thplace (State or in WEST
Director		578-78-6315 1XM	2 F 5 2	Yrs.	Months Days	s Hours IV	OCT	. 5,19	956 <sup>co</sup>	untry IRGINIA
<b>A</b>		Usual Residence of Decedent  10a. State. 10b. County	10c. City. Tow	m es l contin						10d. Inside City Limits
ow any		,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,							1 XYes 2 No
faryland 28a-f show	ģ	MD PRINCE G	EURGE'S DIS		F HEIGH	ITS		10g Citize	n of What Cou	
e Mar or 28; ied ai	Director	6543 PENNSYLVAN	TA AVE #10	- 1	20785			,	ΓED ST	
death with the Maryland or items 23a or 28a-f sho must be notified at once			2. Was Decedent Ever in U.S.		Decedent of His	panic Origin? (	Specify Yes o			Can Indian, Black,
eath v item	Funeral	1 Never Married 2 X Married	Armed Forces?  Yes 2 x No		s, specify Cuban				White, etc.	
filer d		3 Widowed 4 Divorced If		1 \	res 2 X No	specify:		S	pecify: BLA	CK.
hours after natural", c	d by	15. Decedent's Education (Specify only		a. Decedent's	s Usual Occupat st of working life	ion (Give kind o	of work done	16b. Kin	d of Business/	Industry
64 3 -	ompleted	Elementary/Secondary (0-12) 1 2	College (1-4 or 5+)		NITURE		20 1	DDI	TAME	
15-0036 filed within 72 Hygiene. d other than "	шо	17. Father's Name (First, Middle, Last)		FURI		1 N S 1 .	ALLER	1	VATE	
	Be C	MAXWELL H. BLAN	D SR.			INEZ			amamo) .	
2121; wild be fill Mental F marked c event,	To E	19a. Informant's Name/Relationship (Type	e, Print)/_Wîf	19b. Mailing	Address (Stree		Control of the second of the	The state of the s	or Town, State	, Zip Code)
e, MD 2 1 and 2 shou Health and N item 27 is n		JACQUELINE FRAZ	IER-BLAND	1610	BRIGHT	SEAT 1				, MD.20785
or Heal		20a. Method of Disposition  1 X Burial 2 Cremation 3	Removal from State   Crem	atory or other	ion (Name of cei er place)		Date	20c. Lo	cation - City or	Town, State
Pages sent or ant: I		4 Denation 5 Other Specify:	LIN.	MEMO	RIAL (	CEM. 1.	/3/09	SUI	TLAND	, MD.
Baltimore, permit. Pages 1 an Department of Her Important: If ite injury or other tr		21. ature of Funeral Sen ce License	1.00.	22. Na	me and Address	of Facility C	APITOI	MORT	HARY	
		23). Part I. Enter the dise s, or complications. List only on ause on each	son jalle	4 1142	5 MARY	LAND	AVE	N E	WASH.	20002
Physician /Medical		failure. List only on ause on each	line.	Tot enter the	i mode or dying,	Sucri as cardia	c or respirator	y arrest, snock	, or near	Between Onset and Death
xaminer		Immediate Cause (Final Msease a. H)	pertensive Atherosclero	tic Cardio	vascular Dis	sease				Death
		Sequentially list conditions, b.	5 to (c. us u seniosquentes oi).			1	1			
	ner	if any, leading to immediate Du cause. Enter Underlying Cause	e to (or as a consequence of):							
	Examiner	(Disease or injury that initiated C	e to (or as a consequence of):							-
executed an and al - transit		d.								
oe exe ician a	ledical	UNPENDED	AMENDED							
760, ficate be ex g physician the burial	/Me		23c. If yes, outcome of pregnand			Ectopic pre			Date of deliver	•
Sox 687 leath certifi e attending for use as 1	ciar	past 12 months?	1 Live birth 4 Pregnant at time of death	2 Feta	er (Specify)	Ectopic pres	griaticy	l IV	lonth	Day Year
Box 68° e death certification the attending ed for use as	Physician/M	1 Yes 2 No 9 Unknown	9 Unknown	0				_		
res that the signed by leed detached	by PI	Part II. Other significant conditions co	ontributing to death but not result	ting in the ur	derlying cause (	given in Part I.				the cause of death?
S, P nires ti de d							- 1			bably 4 🗹 Unknown
ord:	Be Completed	J				_	_   6	Vas an autopsy	prior to	utopsy findings available completion of cause of
Rec The la cate h	E							erformed? 'es 2 No	death? 1 ✔ Y	es 2 No
tal Re	ge C	25. Was case referred to medical examiner?				of Death (Che				
F Vit	0	1 ✓ Yes 2 No  27. Manner of Death		/Outpatient	·		rsing Home 5	Residence	ce 6 🗸 Othe	r: Scene
Division of Vital Records, rate are Attending Physician: The law requirant and are are at the area of the area of the area of the area of the funeral director, page 2 should led in by the funeral director, page 2 should	on:	1 Natural 5 Pending	28a. Date of Injury (Month, Day,Year)	b. Time of In		ry at Work? Yes 2 No	Zod. Desc	ribe now injury	decurred	
Sion Attend r death rector: by the	icati	2 Accident Investigation	28e. Place of Injury - At home	. farm. street			28f. Locat	on (Street and	Number or R	ural Route Number, City
Division of Vital Records, P.O. Box 68760, ospital or Attending Physician: The law requires that the death certificate be hours after death. After this certificate has been signed by the attending physicily filled in by the funeral director, page 2 should be detached for use as the burity	Certification: T	3 Suicide 6 Could not be determined	(Specify)	,,	,,,	g,		wn, State)		,
Hospi 24 hou Funer tely fil	al C	29a. Certifier Certifying Physician	: To the best of my knowledge, of	death occurr	ed at the time, d	ate and place, a	and due to the	cause(s) and	manner as sta	red.
To the Hos within 24 h Fo the Fur completely	ledical	one) 2 Medical Examiner:0	n the basis of examination and/o	r investigatio	on, in my opinior	n, death occurre	ed at the time,	date and place	e, and due to th	ne cause(s)
F 3 F 3	Me	29b. Signature and title of certifier			29c. Licens					nth, Day, Year)
21		OLW.L	pund		O.C.	M.E.		Dece	mber 28, 2	800
n 7		30. Name and address of person who cor			Dame O:	D-lii	MD 0400			
10			ssistant Medical Examin	er 111	Penn Street	, Baitimore,	IVID 21201			
S <sup>.</sup> Regis	tate trar	31. Date filed (Month, Day, Year)  DEC 3 1 2008	32. Registrar's Signature	Me						
-3.0	_									

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Betty Brenner Ballentine December 26 2008 12:10 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ravenwood Lutheran Village Hagerstown Washington If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Jan. 29,1927 5. Social Security Number ge (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🕅 F 81 Director 219-20-3208 Marvland Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.

em 27 is marked other than "natural", or items 23a or 28a-f show wher traumatic event, its Wordcal Exact insertion to confine 10c. City, Town or Location 10d. Inside City Limits 10b. County Maryland Washington County Hagerstown 1 □Yes 2 TANo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21742 311 Chartridge Dr. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No White 2 Specify: 3 Midowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Personal Residence 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be L.Donald Brenner Blanche Hollingsworth 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health of Item 27 Is Robert H. Ballentine-son 12 Garden Court Front Royal, VA 22630 3altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State permit, Pages 1
Department of H
Important: If iter
any Injury or ott tX Burial 2 ☐ Cremation 3 ☐ Removal from State Rest Haven Cemetery | 12-30-2008 | Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 1331 Eastern Blvd. North 21. Signature of Funeral Service Licenses Hagerstown, MD 21742 Douglas A. Fiery Funeral Home Muclos. 23a. Part 1. Enter the disease, or complications that caus in the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** asulan disease or condition resulting in death) IMOUIL /Medical Due to (or as a consequence of): Examiner netostalu if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 🌿 Unknown 24a, Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 □ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 12.27-2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 368 Street Heyston 1910. 2/740

DHMH 17 Rev 1/2001

State

Registrar

DEC 3 9

Maryland 21215-0036

P.O. Box 68760,

of Vital Records,

Division

istrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 43437 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician Year Joseph Anthony Budsock 2008 NEC \$1:57 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE SAINT AGNES HOSPITAL None 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours **XX**M 2□ F 179-18-2769 85 Director 3-11-1923 PA Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Modical Examination must be notified at Director 1 ☐ Yes 2 No MD Baltimore Catonsville 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 2112 Edmondson Ave. 21228 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Deceded ned Forces? Yes 2 No 72 hours after 1 Never Married 2 Married Yes Maryland 21215-0036 If Yes, Give Year or Dates: 1943–46 1 ☐Yes 2 🛣 No Specify 2 Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Nental Hygiene. Important: If item 27 is marked other than any injury or other traumatic access and other traumatic access and other any injury or other traumatic access and other acces Elementary/Secondary (0-12) College (1-4or 5+) Quality Control Engineer Westinghouse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Anthony Budsock Alice Yurkonis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth J. Budsock / Wife 2112 Followidson Ave., Catonsville Mp 21228

Date of Disposition (Name of Date 20c. Location - City or Town, State Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition, 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet. 1-9-2009 Owings Mills, MD 21. Signatur of June 22. Name and Address of Facility Harry H. Witzke's Family FH M01411 4112 Old Columbia Pike, Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final aTERMINAL METASTATIC LUNG CANCER Physician GMONTHS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner NON RESECTABLE BLADDER - MONTHS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day signed by the a 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CORONARY ARTERY DISEASE 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should PERTENSION 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy RENAL certificate FATLURE perform 1 □Yes 2 **130**No 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ∐ Yes 2 Mo Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Appatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of

BUD SOCK, JOSEPH of Vital this After Division

funeral director, Hospital or Attending ours after death. neral Director; A filled in by the ft. 24 hours a completely To the within 2

EG

31. Date filed (Month, Day, Year) State

Medical

1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

28c. Injury at Work?

29d. Date signed (Month, Day, Year)

1730335878

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DEL PILAR MORALES

100 CATON AVE BALTIMORE, MD 21229 32. Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Natural
2 Accident

3 ☐ Suicide

29a. Certifier

4 T Homicide

(Check only

5 Pending investigation

6 ☐ Could not be

State of Maryland / Department of Health and Mental Hygiene 43438 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Dec 29, **Physician** Janet Kubiavk Brown 2008 4:30 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 70 Village Street Waldorf Charles 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Oct 20, 19 Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 □ M 2 🖫 F 391 16 2675 85 1923 Wisconsin Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10h County 28a-f show traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Director MD P.G. Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò death with 9904 Williamsburg Drive 23a 20772 United States Funeral Items 2 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 Ness, Give If Yes, Give Year or Dates: Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No ö Specify: White Specify. ≥ 3XXWidowed 4 □ Divorced "natural", Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event, Inc. M. Once. Elementary/Secondary (0-12) College (1-4or 5+) 12 US Government Accountant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Kubiayk Jennie Korda ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John L. Brown (SON) 5659 Governors Pond Circle, Alexandria, Va 22310 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1/07/2009 1 XX Yurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cheltenham, Maryland Maryland Veterans Cemetery 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d 21. Signature of Funeral Service 200153 Alexandria Ferry Road, CLinton, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Atherosclerosis Cardiovascular Disease 12 Years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-transit be exect Due to (or as a consequence of): P.O. Box 68760, signed by the attending physician be detached for use as the buria Physician/Medical law requires that the death certificate the as IF FEMALE: for use 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? has e Hospital or Attending Physician: The I 24 hours after death. e Funeral Director: After this certificate ha 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 26. Place of Death (Check only one)

Other: 4 □ Nursing Home 5 □ Residence 6 ②

Other: 4 □ Nursing Home 5 □ Residence 6 ②

Other: 4 □ Nursing Home 5 □ Residence 6 ②

Other: 6 ○

Other: 1 ☐ Yes XXNo 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Laminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. To the within 2 29b. Signature an 29c. License number 29d. Date signed (Month, Day, Year) 52741 12/29/08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Caroline Caine 11701 Livingston Road #103, Fort Washington, MD 31. Date filed (Month, Day, Year) State DEC 3 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene State
Registrar #31, per hd, 1/5/09, tj Certificate of Death Amend item 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year Physician 2008 2:02**8**M Sarah Barnette /Medical 4a. Facility Name (If not institution, give street and number)

Manok In Manor 4c. County of Death 4b. City. Town, or Location of Death Examiner Under 1 Year If Under 24 Hrs. lanokin Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** Months Days Hours 1 M 2 F Yrs. 214-18-4788 87 08-28-1921 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County "naturel", or items 23s or 28s-f show 1 Yes 2 No Somerset Princess Anne Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 11974 Edgehill Terrace 21853 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 □ Divorced þ White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Homemaker none Own Home 18. Molher's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 2 should be fi and Mental F ie marked of Moffitt Hoffman Ruby Hoffman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health a Important: if item 27 le eny injury or other trat once. John Barnette/Son 13250 Pruitt Lane, Princess Anne, MD 21853 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 Burial 2 Cremation 3 Removal from State Grace Episcopal Cem. 01-03-2009 Mt. Vernon, Maryland - □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Hinman Funeral Home Signature of Funeral Service Licensee Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. M00295 11673 Somerset Ave., Princess Anne, MD 21853 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ASCUB **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by DEMIENTTA 1 Yes 2 No 3 Probably 4 Onknown 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2□ No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မှ After thi 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Deatural 2 Accident 5 Pending М 1 ☐ Yes 2 ☐ No investigation Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funerel I 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number mo JANUART 2, 2009 20062916 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DIVISION EUTTERSENSBARAMDEROU 1415 SonoA Guntennez SVERANA 2009 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

マア

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day Year **Physician** 30,2008∥6:38pm<sup>M</sup> James Henry Brown December /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Prince Georges Hospital Cheverly Prince Georges If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) Funeral †**⊈** M 2□ F Months Days Hours Director 230-54-3221 66 October 5,1942 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10a State 10d. Inside City Limits shov ?7 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Wedical Evanirar must be notified at Director 1XYes 2 □ No Capitol Hghts Prince Georges 10e. Street and Number 10g. Citizen of What Country? Funeral 6313 Morocco Street 20743 U.S.A 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 ☐ Never Married 2 ☐ Married 1 ∐Yes 2 ⊠ If Yes, Give Year or Dates: altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: black ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, In. Ma. Once. Elementary/Secondary (0-12) College (1-4or 5+) Printer Government 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Charles Brown Sr. Mary Holmes 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Hawkins 3200 M. Street SE Washington, DC 20019 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Harmony 4 ☐ Donation 5 ☐ Other (Specify) Jan.7,2009 Landover, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Suitland, F.H. 3910 Md 20746 Hodges&Edwards F.H. 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician pulmonomy Edemo /Medical Due to (or as a consequence of): Examiner Remol Sequentially list conditions, it any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last epsis ed by the attending physician and detached for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 18ertension IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) 9 Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death? performe certificate 2 🖪 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: '24 hours after death.
Funeral Director: After this certificately filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending 1 ☐Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 / Homicide 24 hours a 29a. Certifier 1 Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical within 24 ho

To the Fune

completely f (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) r. Bldella D0059981

State Registrar

DHMH 17 Rev 1/2001

Mukemil
31. Date filed (Month, Day, Year)

32. Registrar's Signature

JAN 1 0 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

And ella, mo

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Charles Windel Cross December 8:18 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Washington Adventist Hospital Tokoma Park Montgomery County Hours Min. 8. Date of Birth (Month, Day, Dec. 19, 5. Social Security Number 6. Sex 1 M 2 □ F If Under 1 Year 9. Birthplace (State or Foreign Country) West Virginia 7. Age (In yrs. last birthday) **Funeral** Months Days Yrs 213-40-5131 68 Director 1940 Usual Residence of Decedent filed within 72 hours after death with the Maryland Pages 1 and 2 should be filed within 72 hours after death with the Marylann nent of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Wellen Exa., the matter be roulled. 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No Maryland Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2322 Kent Court 20602 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify. þ 3 ☐ Widowed 4 ☐ Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Financial Analyst Fairfax County School 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Luther Levi Cross Dora Nestor 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Iris Cross/ Wife 2322 Kent Court, Waldorf, Maryland, 20602 Department of Health Important; If item 27 any injury or other troops 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🛣 Cremation 3 Removal from State Huntt Crematory 4 Donation 5 Dother (Specify) Jan. 3, 2009 Waldorf, Maryland 21. Signature of Funeral Service Lie 22. Name and Address of Facility Huntt Funeral Home 01190 3035 Old Washington Rd. Waldorf, MD. 20601 23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician avanan disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner d any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a sonsequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician hed for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed peen Was a... autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? has 24a. Was an certificate 2 No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death

1 ☑ Natural

2 ☐ Accident 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 | Pending death. investigation 1 ☐ Yes 2 ☐ No within 24 hours after deatl To the Funeral Director: 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Wedical Exempler: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature tifier 29d. Date signed (Month, Day, Year) Name and addu pleted cause of death (Item 23a) (Type, Print 600 Mall 31. Date filed (Month, Day, Year) State Régistrar's Signature parks JAN 0 5 2009 Registrar

			for State Registrar	State of	Maryland / Dep <i>Ce</i>	artment of ertificate of		Mental Hyg	iene <sub>eg. No</sub> 20 (	08 43442
	Physic	an	Decedent's Name (First, Midd.     Hulda Louise					2. Date of Death Month December	h	3. Time of Death
	/Medi Examir		4a. Facility Name (If not institution		ber)	4b. City, Town, o	or Location of Deat		4c. County of	
all.			Anne Arundel M				colis			Arundel
	Funeral		5. Social Security Number	6. Sex 7 1 ☐ M 2X F	. Age (In yrs. last birthday	Months Days		8. Date of Birth (Month, Day,	Year)	9. Birthplace (State or Foreign Country) Washington, D.
	Director		579–18–4931 Usual Residence of Decedent	1 - W - ZA-1	89 Yrs.			Nov. 7,	1919	Washington, D.
	/land		10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	Man 3-f sh	혅	MD Prin	ce George':	s Bowie					1 <b>½</b> Yes 2□No
	or 28	Director	10e. Street and Number	00 000190		10f. Zip Code		10	0g. Citizen of Wh	nat Country?
	23a	la I	12319 Stonehav	en Lane	529	2071	5		USA	
920	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or items 23a or 28a-f show ent, the Medical Exactions must by rollified at	by Funeral I	11. Marital Status 1 ☑ Never Married 2 ☐ Mar 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedon Armed Force ried 1 Tyes 2 If Yes, Give Year or Date	es? ••••••••••••••••••••••••••••••••••••	Was Decedent of If Yes, specify Cub 1 ☐ Yes 2 ▼No	Hispanic Orlgin? (S pan, Mexican, Puerl Specify:	pecify Yes or No- o Rican, etc.)		- American Indian, White, etc. White
5-0	72 hol	Completed	15. Deceden (Specify only highe	t's Education	16a. Dece	edent's Usual Occu	pation	deina 1	16b. Kind of Busi	ness/industry
21	ithin ne.	du	Elementary/Secondary (0-12)	College (1-4	UI ()+)		during most of wor ed)	Kirig		Aviation
2	lled w lygie ther ti	ပိ	17. Father's Name (First, Middle,		Secr	etary		VE: 4 A41 A 11		ministration
Baltimore, Maryland 21215-0036	be ad c	To Be	John R. Coomes	,				<sub>ne (First, Middle, M</sub> uise Clif	,	
ary	s 1 and 2 should if Health and Mer Item 27 is marke other traumatic	-	19a. Informant's Name/Relations		19b. Maili	ng Address (Street	1	ıral Route Number,		tate, Zip Code)
Σ,	of Health of Health of Item 27 is		Myrtle K. Fish	er/friend		312 Wind:			MD 2071	
ore	ges 1 at of He III if item		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	27 Romoval from Ct	20b. Place of Disponder.	osition (Name of matory or other pla	ce)	Date 2	20c. Location - Ci	ity or Town, State
Ë	Pages Iment of Iant: If it		4 □ Donation 5 □ Other (S		Ce	metery	11/2/			on, D.C.
Ball	permit. Pages Department of Important: If i any injury or once.		21. Signatur of Fulleral Service	Licensee			<sup>ess of Facility</sup> Be rain Hwy.	all Funer Bowie,	al Home MD 207	
	Physician //		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	_a. Cecot	DIAL VASIL	ter the mode of dyl	21.	or respiratory arre	st,	Approximate Interval Between Onset and Death
8760,	cate be executed by physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or	as a consequence of):  A A A A A A A A A A A A A A A A A A A					
P.O. Box 68	the death certific y the attending p iched for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 ponths? 1 □ Yes 2 ☒ No 9 □ Unknown		h 2 ☐ Fetal death 3 [ nt at time of death 5 [	☐ Ectopic pregnanc☐ Other (specify) _	зу		23d. Date of Month	,
Records, F	law requires that nas been signed b 2 should be deta	Completed by P	Part II. Other significant condition	- L Cilia	h but not resulting in the u	nderlying cause giv	ven in Part I.			ute to the cause of death?
9 0 0	e law re has bee	plet	Athrosclerohe	Henrt dise	ase			24a. Was an	24b. We	re autopsy findings available
Ä	<b>hysician:</b> The la his certificate ha I director, page 2	Com	Acute Renal Fa	nilure				autopsy performe 1 ☐ Yes 2	ed? dea	or to completion of cause of ath? ]Yes 2 □ No
/ita	cian: sertific	Be (	25. Was case referred to medical examiner?					th (Check only one)		
of \	Physical this call dire	P	1 Yes 2 No		atient 2 ER/Outpatier		4 LI Nursing H	ome 5 ☐ Residen		(Specify)
no	ding Ph h. After th funeral	io	27. Manner of Death  1 Natural 5 □ Pending 2 □ Accident investig		njury 28b. Time o Day, Year) Injury	Wor	ryat k? Yes 2 ∐ No	28d. Describe how	v injury occurred	
Division of Vital	al or Atten after deat I Director; d in by the	Certification:	2	at he	Injury - At home, farm, str etc. <i>(Specify)</i>		res 2 DINO	28f. Location (Stre City or Town,	eet and Number ( State)	or Rural Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical C	29a. Certifier 1 → Certifyin (Check only one) 2 → Medical	g Physician: To the be Examiner: On the basi and manner	est of my knowledge, deat s of examination and/or in stated.	h occurred at the til vestigation, in my c	me, date and place ppinion, death occu	, and due to the car rred at the time, dat	use(s) and mann te and place, and	ner as stated. If due to the cause(s)
	To the comp	ž	29b. Signature and title of certifier			29c. Licens	e number	290	d. Date signed (A	Month, Day, Year)
	1200	)	May / V	70		D640	189	1.	2/29/0	Y
	10'CD		30. Name and address of person	who completed cause o		Print)	^		7	<i>y</i>
	14	.0	31. Date filed (Manus, Day, Yea)	2000 34 Regi	strar's Signature	erkway	Donapoli	- MD	21401	
	Stat Registra		ከ೯ሮ.3.0	2008 Cerso	strar's Signature	Made				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day December 28 2008 12:30 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Wicomico Nursing Home Salisbury Wicomico If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F 15.44.677 02 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No 10r. Zip Code 10g. Citizen of What Country 10e. Street and Number Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc (Wiccmico 1 Tes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 ☐ No timore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. \$ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Father's Name (First, Middle, Last) Mother's Name (First, Middle. Maiden Surna Be 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City Town, State, Zip Code) Log Cabin 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 1☐Burial 2 ☐ Cremation 3 □Removal from State 4 □ Donation 5 □ Other (Specify) 21. Sign Illia of Funeral Service Licensee n Bennie Smith Furnal Home 917 W. Isabella St. Salishury Md 21801 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23a. Part1. Enter the disease shock, or heart failure. proximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine that the death certificate be executed burial-trar Due to (or as a consequence of): Box 68760 physician Physician/Medical the attending IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.0. ed by the a detached f 9 Unknown cate has been signed I page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Was an autopsy performe certificate Division or Vital 2 No 2 No the Hospital or Attending Physician: funeral director, 25. Was case referred to nedical Be 26. Place of Death (Check only one) examiner? Other: 1 Tes 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) the Funeral Director: After this of the funeral Director After this of the funeral director filled in by the ဥ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manual of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation (Month, Day Year) 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 2 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 1/2001

State

parke

614 Easternshore Dr

Salisbury MD 21804

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Mahesha Thimmarayappa M.D.

Day, Year)

JAN05

31. Date filed (Month,

08-09588 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Linda Cunningham State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day December 21, 2008 **Medical Examiner** 1116 hrs Linda Marie Cunningham 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Frederick Memorial Hospital Frederick Frederick 5. Social Security Number 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Hours Director Country) Connectiout 2 X F M 2/16/1955 217-72-4308 53 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County Yes 2 X No or items 23a or 28a-f show must be notified at once. Maryland Frederick New Market Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 11101 Eagletrace Drive USA Funeral 12. Was Decedent Ever in U.S 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 X Married Yes 2 X No permit. Pages I and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", o injury or other traumatic event, the Medical Examiner 1 If Yes, Give Year 3 Yes 2 X No specify: Specify: White Widowed 4 Divorced þ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry ted during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+ Baltimore, MD 21215-0036 Visual Merchandising Special. Department Store 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be William Marion LuCree <u>Rose Ann Mestre</u> 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eagletrace Drive, New Market, Maryland 21774 11101 Martin Thomas Cunningham. husb 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Souls Cemetery 12/29/2008 Germantown, Maryland Donation 5 Other Specify 22. Name and Address of Facility Molesworth-Williams Funeral Home 21. Signature of Funeral Service Lio-26401 Ridge Road, Damascus, Maryland 20872 a l. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failule. List only one cause on each line. Aspiration pneumonia and fat emboli status post Approximate Interval **Physician** Between Onset and Medical Death a abdominaplasty and liposuction Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and transit Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical AMENDED 23a, 27, permE, g887 1/20/.09 TT the attending physician ed for use as the burial -UNPENDED Box 68760 IE EEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Ectopic pregnancy Month Day Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) detached for Yes 2 No 9 ✓ Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Yes 2 No 3 Probably 4 ✔ Unknown page 2 should be Completed Records. 24a. Was an 24b. Were autopsy findings available has been autopsy prior to completion of cause of performed? death? Yes 2 certificate Yes No 1 26.Place of Death (Check only one) Division of Vital 25. Was case referred to medica Be examiner? Other<sub>4</sub> Hospital: DOA Inpatient 2 V ER/Outpatient 3 Nursing Home 5 Residence 6 this 2 1 Yes No funeral After 27. Manner of Death 28a. Date of Injury (Month, Day, Year 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: X Natural n 24 hours after death
e Funeral Director: A
letely filled in by the fu 1 Yes 2 No Pending Investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide determined Homicide 29a. Certifier 1 within 24 ho

To the Fune

completely f Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. December 22, 2008 Um 30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) Registrar's Signature State Registra ORIGINAL

DHMH 17 Rev 1/2001 OCME 2006

215 Barksdale Ave

1 ☐ Never Married 2 ☐ Married

3 XWidowed 4 ☐ Divorced

17. Father's Name (First, Middle, Last)

19a. Informant's Name/Relationship (Type. Print)

4 Donation 5 Dother (Specify)

21. Signature of Fune Jorvice License

1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State

Bernard

20a. Method of Disposition

Funeral

9

Completed

Be ပ

permit. Pages 1 and Department of Heal Important: If Item 2 any injury or other once.

Physician

Examiner

/Medical

Examine

Physician/Medical

2

Completed

Be

Medical

examiner?

29a. Certifier

1∐Yes 2 No

11. Marital Status

harles Plata Year If Under 24 Hrs. 8. Date of Birth
Days Hours Min. 09/17/1921 9. Birthplace (State or Foreign Country)
Maryland Days 10d. Inside City Limits

2. Date of Death

ecember

Month

10f. Zip Code 10g. Citizen of What Country?

20602 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐Yes 2 No Specify:

Specify: Black 16b. Kind of Business/Industry

Waldorf Maryland

Reg. No. 2008

4c. County of Death

2008

4:55 AM

1 XYes 2 □ No

Day

15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic

16a, Decedent's Usual Occupation

18. Mother's Name (First, Middle, Maiden Surname) Marshall Mary J. Brown

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane Jones /Daughter

2308 Timbercrest Dr. Forestville MD 20743 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State St.Peters

01/05/09

22. Name and Address of Facility

Adams Funeral Home PA, Aquasco, MD20608 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final ongestive disease or condition resulting in death) Due to (or

s a consequence of)

Due to (or as a consequence of):

Due to (or as a consequence of):

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates:

if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE: 23b. Was decedent pregnant

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

3 Ectopic pregnancy

5 ☐ Other (specify)

Month

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. (Yulmonary Embolism

Interstitial Lung

24a Was an

1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

200 V

Day

Year

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 □ Yes 2 No

23e. Did tobacco use contribute to the cause of death?

23d. Date of delivery

25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DCA

27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 No

2 Accident 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check of one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Ifay, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

office Road Waldorf, MD Post Sona

Chon 31. Date filed (Mototh, Day, Year) 32. Registrar's Signature

JAN 0 5 2009

State Registrar

completely

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

death certificate be executed burial-tran and Box 68760, attending physician for use as the burtal been si certificate director, After this funeral c e Hospital or Attending P 24 hours after death. e Funeral Director; After t filled in by the 24 hours a

signed by the a page 2 s Certification: To

P.O. Records,

Division of Vital

within 2

amend line 10e-f per fd aaco hlth dept 01/05 lease Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Mina Dice December 26, 2008 3:40 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Center Heritage Harbour Health and Rehab. Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Davs Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 200 F Yrs Director 578-34-6296 79 May 13, Maryland Usual Residence of Decedent the Marylend 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 7 is marked other than "natural", or frams 23a or 28e-f show treumatic svent, the Medical Examinar must be rightled at 1⊠Yes 2 No Director Anne Arundel Annapolis 10e. Street and Number 2700 South Haven Rd 10f. Zip Code 21401 10g. Citizen of What Country? with USA 21403 <del>35 Milkshak</del>e Lane Completed by Funeral filed within 72 hours efter death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ ②No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: Specify: White 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry nd Mental Hygiene. marked other than College (1-4or 5+) Elementary/Secondary (0-12) Sales Clerk Sales 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Peges 1 and 2 should be fill ment of Health and Mental Hent: If item 27 is marked off jury or other treumatic sven Be John W. Pforter Evangelina L. Abbott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janice M. Perrone/Daughter 711 Howards Loop Annapolis, MD 21401 20b. Place of Disposition (Name of cemetery, crematory or other place)
Park Lawn Memorial 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Pege Department of Importent: If any injury or 2002. 12/30/2008 Rockville, Maryland 4 □ Donation 5 □ Other (Specify) Park 21. Signature of Fu eral Service License 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy. Bowie, MD 20715 23a. Part 1. Enter the disease, or compile tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 00 Johns year. /Medical Due to (or as a consequence of : **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Examiner Due to (or as a consequence of): The law requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 Other (specify) ed by the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 🗌 Yes 2 No To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 X ursing Home 5 - Residence 6 - Other (Specify) 1 ☐ Yes 2 No Certification: To completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Director: After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 004051 12-29-08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1667 CROFTON CENTRE, SAITE I CROFTON MD 21114 MIRZA NUSAIREE Registrar's Signatur Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death December 29, Physician 2008  $a^{M}$ 6:30 Clarice Evelyn Denny /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Charles LaPLata 6290 Ripley Road If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, January) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8,1917 1 □ M 2 F 91 Maine 213-44-7192 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 27 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Modical Examinat must be ricitified at 1 ☐ Yes 2 XNo Director LaPLata Charles Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 20646 6290 Ripley Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. s 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. item 27 is marked other than "natural", or Iter 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify. ò 3 Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Home Nurse Practical Nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Georgia H. Verrill Melzer E. Hartford ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Son 3508 Taylor St., Brentwood, Md. 20722 George Denny, Jr. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date permit. Pages 1 Department of H Important: If iter any Injury or oth 2, 2009 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Waldorf, Maryland Trinity Memorial Gardens 22. Name and Address of Facility
Williams Funeral Home, P.A.
4270 HAwthorne Rd., Indian Head, Md. 21. Signature of Funeral Service Licens M00668 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart halfere. List only one cause on each line. Immediate Cause (Final CARCINOMA **Physician** FW MOM disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if an leadin to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine requires that the death certificate be executed and burial-trai Due to (or as a consequence of): Box 68760, physician Physician/Medical the attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 1 ☐ Yes 2 No P.O. signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, δ METASTASIS 1 ☐ Yes 🚧 No 3 ☐ Probably 4 ☐ Unknown Completed peen : 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this after death.

I Director: After this d in by the funeral di 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Division or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined completely filled in by within 24 hours after To the Funeral Direct 4 - Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier cal (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 44436 Bach ENDING 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PAULMElloN CT WALDORF My 20602

Registrar DHMH 17 Rev 1/2001

State

ASHVINKUMAR

Year)

JAN 0 5 2009

31. Date filed (Month, Day,

PATEL MY) 32. Registrar's Signature

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2015 M Physician 12 /Medical County of Death Facility Name (If not institution, give street 4b. City, Town, or Location of Death Examiner SALISBURY Wicomico If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country): 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) **Funeral** 1 M 2 F **Director** 10a. State 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Its Medical Examinat must be notified at 1 Wes 2 No Director Zip Code 10g. Citizen of What Country Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital State Black, White, etc 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No <u>ک</u> 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) Be e litime ၉ Mailing Address (Street and Num) 20b. Place of Disposition (Name of cemetery, crematory or other) 20a Method of Disposition 1 □ Burial 2 □ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Appromate Interval Between Onset and Death 23a. Part 1. Enter the dicease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear vailure. List only one cause on each line. Immediate Cause Final **Physician** disease or condition resulting in death) areinema /Medical Due to (or as a consequent of) Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown 3 Ectopic pregnancy Day 5 Other (specify) signed by the a 1 ☐ Yes 2 🗷 No P.0. g ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, <u></u> 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 1 ☐ Yes 2 No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28d. Describe how injury occurred 1 🔼 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

29a. Certifier

(Check only one)

29b. Signature and title of certifier

GREGORIO M. BELL JAN 05

Medical

DHMH 17 Rev 1/2001

Registrar

and manner stated.

80. Name and add ess of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

D29505

OSO, M.D.: 5302 CHINABERRY DR., SALISBURY, MD 21801

29d. Date signed (Month, Day, Year)

12-27-2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month December 26, **JEAN** W. ELIAS /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death County of Death 6-eorge's Chever Trince C If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Sev 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 🖾 F Days Hours **Director** 214-13-0088 JAN 28 1932 GUYANA Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or items 23a or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits event, the Medical Experiment nust be notified at Director M Yes 2 No PRINCE GEORGE'S LANDOVER HILLS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral I 4005 SPIREA COURT 20784 IISA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Race - American Indian, Black, White, etc. 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married þ 1 ☐ Yes 2 No Specify BLACK Specify: 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th HOUSE WIFE PRIVATE 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) REGINALD BELL ည LUCILLE JOSEPH 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ANNABELLE GLASGOW / DAUGHTER SPIREA COURT LANDOVER HILLS, MARYLAND 20784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1 Department of P Important: If ite any Injury or ot once. 1 DIBurial 2 ☐ Cremation 3 ☐ Removal from State LINCOLN CEMETERY 1/3/2009 BRENTWOOD, MARYLAND 21. Signature of Fun Service Ucensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Diration Due to **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine ending physician and use as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 🗆 Ectopic pregnancy ō Month Day Year 5 ☐ Other (specify) cate has been signed by the a page 2 should be detached a 9 Unknown 9 Dunknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2☐No 3☐ Probably 4☐ Unknown 1 □ Yes 24a. Was an Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed 2 No 1 ☐ Yes 2 1 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occupred fatient was extry 1702 became obstructed by food 28b. Time of 5 Pending investigation 1 Natural To the Hospital or Attendition within 24 hours after death.

To the Funeral Director: A December 1620 5 11.30 M 12 28e. Place of Injury. At home, farm, street, factory, office building, etc. (Specify) 2 Accident 1 ☐ Yes 2 ☐ No filled in by the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number City or Town, State) 1005 Spires G determined 4 ☐ Homicide home new Carrotton

or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

State Registrar

Medical

29a. Certifier

(Check only one)

DEC 3

29b. Signature and title of certifier

32. Registrar's Sign 31. Date filed (Month, Day, Year) 1 2008

3001

30. Name and address of person wire completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

1. Decedent's Name (First, Middle, Last)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg. No.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year Physician 11.43 PM DECEMBER 29 2008 FRANKLIN GROVE JR. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WASHINGTON COUNTY HOSPITAL HAGERSTOWN WASHINGTON If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 ₩ 2 □ F Director 217-28-6073 76 APRIL 27,1932 MARYLAND Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show s 23a or 28a-f showers that the notified at 1 ☐Yes 2 No Director BOONSBORO MARYLAND WASHINGTON 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 8414 TUSINGS WAY 21713 U.S.A. permit. Pages 1 and 2 should be filed within 72 hours after dear Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or itemany injury or other traumatic event than "natural" or itemany injury or other traumatic event than "natural". 12. Was Decedent Ever in U.S.
Armed Forces?
1 ⊠Yes 2 □ No KOREAN
If Yes, Give
Ye ar or Dates: WAR items Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 ☑ No Specify þ 3 Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 9 MAINTENANCE TECHNICIAN APARTMENT COMPLEX 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JOHN FRANKLIN GROVE SR. MARGUERITE NEWCOMER ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JANE R. GROVE/SPOUSE 8414 TUSINGS WAY, BOONSBORO, MARYLAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Spe MANOR CHURCH CEMETERY 1/02/2009 | BOONSBORO, MARYLAND 22. Name and Address of Facility BAST-STAUFFER FUNERAL HOME 21. Signature of Funeral Service Licen - e Paul M. Dean 7606 Old National Pike, Boonsboro, MD 21713 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease of complications that caused the shock, or heart failure. List only one cause on each line. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** multi System disease or condition resulting in death) 2-4 hours /Medical Due to (or as a consequence of): Examiner 3-4 ms Sipris Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 3-4 mus Exam and-trai Due to (or as a consequence of) physician a Division of Vital Records, P.O. Box 68760, Physician/Medical attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify). signed by the a d be detached f 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 1 Yes 2 No 3 Probably 4 Unknown has been si ye 2 should t Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy typerlipe len 2 1 No 1 ☐ Yes : After this certific funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 -No 1 🗌 Yes Certification: To 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 1 Matural 5 Pending thin 24 hours after death.

the Funeral Director: A mpletely filled in by the fu death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 - ertifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 To the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) world mo D18019 DEC 30,2003 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MILL ST MAGERSTOWN MD 21740 3H-8 340 MO VASAVT DATTA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

DEC 3 1 2008

			FOI	artment of Health and Me rtificate of Death	ntal Hygien		43452
			Decedent's Name (First, Middle, Last)	2	. Date of Death	ay Year	3. Time of Death
	Physicia /Medic		Frances Marie Gore		ecember :	31, 2008	2:00 P M
	Examin		4a. Facility Name (If not institution, give street and number)  Manor Care Nursing Home	4b. City, Town, or Location of Death TOWSON	1	c. County of Death Raltimore	County
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 1 M 2 MF 75 Yrs.	Months Days Hours Min.	Date of Birth (Month, Day, Yea OV • 15,	9. Birth Cou Mary	place (State or Foreign ntry) Land
	and w		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Liverage	ocation			10d. Inside City Limits
	Maryl -f sho fied a	tor	Maryland Baltimore County Upperco				1 □Yes 2 No
	3a or 28a st be noti	al Director	10e. Street and Number 5222 Byerly Road	10f. Zip Code 21155	"	ited Stat	•
336	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 Is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1  Never Married 2 Married 3  Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces? 1  Yes 2 No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Speci If Yes, specify Cuban, Mexican, Puerto Ri 1 ☐ Yes 2 🎇 No Specify:	fy Yes or No- can, etc.)	14. Race - Ameri Black, White, Specify: Whi	etc.
Baltimore, Maryland 21215-0036	within 72 ho iene. than "natur the Medical E	Completed	(Specify only highest grade completed) (Give	edent's Usual Occupation e kind of work done during most of working DO NOT use retired) Maker		Kind of Business/Ir	ndustry
and 21	ould be filed within Mental Hygiene. arked other than ' atic event, the Me	Be	17. Father's Name (First, Middle, Last) Franklin Howard	18. Mother's Name (i		en Surname)	
Mary	d 2 should be th and Mental ?7 Is marked of traumatic ev	으	1 1 2	ing Address (Street and Number or Rural I	Route Number, City	or Town, State, Zi	
more,	Pages 1 and 2 nent of Health int: If item 27 I iry or other tra		20a. Method of Disposition 20b. Place of Disposition cemetery, cre		an. 6 20c.	Location - City or T	own, State
Balti	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Lice 19 MO1072 9	ne Funera t Hampst	il Home Lead, Mary	yland 21074	
	A		23a. Part1. Enter the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac or	respiratory arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	RAL HEMRRY	1AGE		Onset and Death
	/Medical Examiner		Due to (or as a consequence of):				Weeks
*	ž	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
	cate be executed oblysician and the burial-transit	Examine	that initiated events C.				
30,	oe exe cian al vurial-t	I Ex	resulting in death) Last  Due to (or as a consequence of):				
38760,	icate b physic the b	dical	d				
O. Box 6	The law requires that the death certificate be executed the has been signed by the attending physician and oage 2 should be detached for use as the burial-transit	Physician/Mec		□Ectopic pregnancy □ Other (specify)		23d. Date of deliv Month	v <b>ery</b> Day Year
Δ.	uires that the de signed by the a d be detached i	þ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		o use contribute to	the cause of death?
Vital Records,	The law requir ate has been si page 2 should I	Completed			24a. Was an autopsy performed?	prior to co	opsy findings available ompletion of cause of
tal		0	25. Was case referred to medical	26. Place of Death (	1□ Yes 2 2 1 Check only one)	No 1 ☐ Yes	2 No
Z	g .g .g	To B	examiner?  1 Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatie			6 ☐Other (Spec	ify)
n or	ng fte		27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time Injury	of 28c. Injury at 28 Work?	d. Describe how in		
Division	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No treet, factory, office 28	If. Location (Street City or Town, Sta	and Number or Rui ate)	ral Route Number,
Ω	Hospital of hours af Funeral Districtly filled i		29a, Certifier 1 Certifying Physician: To the best of my knowledge, dea	th occurred at the time, date and place, ar	nd due to the cause	e(s) and manner as	stated.
	ie Hos 24 ho ie Fun eletely	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated.				
	To the within 2 To the comple	Me	29b. Signature and title of certifier	29c. License number	29d. [	Date signed (Month	, Day, Year)
	WJL		Ma Colin belin	61-16849	/	2-31-0	0
	+		29b. Signature and Attiegof ceptifier  30. Name and address of person who completed cause of death (Item 23a) (Type H. E. HILA DI. M. T. T. C. C. D. S. Date filled (Month, Day, Year)  31. Date filled (Month, Day, Year)  32. Registrar's Signature  JAN 0 5 2009	BSLER Dr To	WEON	MD 2	1204
	Sta Regist		31. Date filed (Month, Day, Year)  JAN 0 5 2009  Research	pares			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 9:32a Laura Ruth Glover Dec. 30 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 3929 Sunset Drive Hampstead Carroll If Under 1 Year If Under 24 Hrs. Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Davs Months 1 □ M 2 1 F Director 212-14-8500 3/23/1923 MID Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a State 10d. Inside City Limits 10h County ral", or items 23a or 28a-f show Examiner must be notified at MD 1 ☐ Yes 2 ☑ No Director Carroll Hampstead 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3929 Sunset Drive 21074 Completed by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: white 3 Widowed 4 □ Divorced "natural", the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) sewing factory seamstress Ith and Mental Hygid 27 is marked other r traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental Goldie Wisner Harvey Eugene Buchman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a : If item 27 is or other tra Nancy Ruth Hare, daughter 3927 Sunset Drive, Hampstead, Md. 21074 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department c Important: If any Injury or Jan. 3, 2009 Finksburg, Md. 4 Donation 5 Other (Specify) Evergreen Memorial 22. Name and Address of Facility 21. Signature of Funeral Service Licensee M00741 Eline Funeral Home Semmer 934 S. Main St., Hampstead, Md. 21074 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Due to (or as a consequence of): disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any leading L immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 4□Pregnant at time of death Year Day 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform page 2 No 2 No /1/2 1∐ Yes 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one Hospital: Other: 4 \( \sum \) Nursing Home 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 5 Residence 6 □Other (Specify) After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death. To the Funeral Director: After 1 Natural 2 Accident 5 Pending investigation after death.

I Director: Aid in by the fu 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Deogracias Faustino, M.D. 4111 32 Registrar's Signature Rd., Hampstead, Md. 21074 4111 Lower Beckleysville 31. Date filed (Month, Day, Year) State L'elais. 2008 Registrar DEC 3 1

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens

			For State Registrar	State of Ma	aryland		tificate of		_	GIENE Reg. No.	111123	43454
r	Physici		Decedent's Name (First, Middle, La  Togoph  Tib	,	hin	Тъс.			2. Date of De Month	Day		3. Time of Death 12:00 .P M
No. of London	/Medic Examin		Joseph Th  4a. Facility Name (If not institution, giv		DIII	Jr.	4b. City, Town, o	r Location of Dea	Dec.		2008 County of Death	
	LXamii		Chapel Hill Nur	sing Cente	r		Randalls	stown		Ba]	ltimore	County
31.92)	Funeral		5. Social Security Number 6. S	Sex 7. Ag	e (In yrs. las		If Under 1 Year		s. 8. Date of Bir	th		iplace (State or Foreign intry)
j	Director		210-01-2111	M 2□F	88	Yrs.	Months Days	Hours Will	Mar. 18	19:	20 D.C	•
	and *		Usual Residence of Decedent  10a. State 10b. County		10c City	Fown or Lo	cation					10d. Inside City Limits
	laryla shor	5	Maryland Baltimor	re County		allst						1 ☐ Yes 2 ☑ No
	the N 28a-1 notifi	rect	10e. Street and Number				10f. Zip Code			10a Citiz	zen of What Cou	
	with 3a or 1 be	Funeral Director	10908 Steffeny Ro	pad			21133			_	ed State	•
	ms 2;	Jera	11. Marital Status	12. Was Decedent	Ever in U.S.	13. V	Was Decedent of H f Yes, specify Cuba	ispanic Origin? (			14. Race - Amer	ican Indian,
Maryland 21215-0036	be filed within 72 hours after death with the Maryland ntal Hygiene. et other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	Armed Forces? 1 X Yes 2 ☐ I If Yes, Give Year or Dates:	∾o WW II		fYes, specify Cuba I□Yes 2 <b>X</b> No	an, Mexicañ, Pue <i>Specify:</i>	rto Rican, etc.)		Black, White Specify: wh:	
2	72 hc natu	etec	15. Decedent's Ed	ducation ade completed)		16a. Deced	lent's Usual Occup	ation during most of we	arkina	1	nd of Business/li	•
21	ithin ne. han "	Completed	Elementary/Secondary (0-12)	College (1-4or 5	i+)	<i>∖iife. t</i> Machi	kind of work done OO NOT use retired nict	1)	g		per and	Brass
7	filed w Hygiei Ither th	Ö	47. Satharia Nama (Sinet Atiddle 1 and			raciii	IIIDU	40 Martin de Mi	/F:		pany	
anc	ould be fi Mental H arked ot atic ever	Be	17. Father's Name (First, Middle, Last, Joseph Thomas Gr					Laura	me <i>(First, Middle,</i> White	, Maiden S	Surname)	
Ž	2 should be and Mental Is marked (saumatic ev	ဥ	19a. Informant's Name/Relationship (			19b. Mailin	g Address (Street	and Number or F	Rural Route Numb	er City or	Town State 7	in Code)
Ma	D # 17 # G		Jay Gribbin — sc				Steffen		Randalls			
re,	s 1 and 3 f Health item 27 other tr		20a. Method of Disposition	_			sition (Name of natory or other place	•	Date		cation - City or T	
E	Page nent c nt: If iry or		1 ☐ Burial 2 X Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		Carr	oll C	remation	ຶ່ 12/	31/2008	Hamps	stead, 1	Maryland
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		21. Signature of Funeral Service Licer	vee	M0107	22	. Name and Addre	ss of Facility	Eline Fur	neral	Home	
	99 = 20			urvn		934	4 S. Main	St. I	Hampstead	d. Ma		
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each lir	the death. ne.	Do not ente	er the mode of dyin	g, such as cardia	ac or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	_a			otic ceve	bral Vo	ascula	diss	250	Jeavs
	Examiner			Due to (or as	a consequer	nce of):		92				
120		e.	Sequentially list conditions, if any, leguing to immediate	b. Due to (or as	a cur sequer	ició uty:						
	cuted id ransit	Examiner	Sequentially list conditions, if any, leading to inimidate cause. Enter Underlying Cause (Disease or injury that initiated events	C.								
Ő,	e exe ian ar urial-t	Ë	resulting in death) Last	Due to (or as	a consequer	ice of):						
68760,	ifficate be executed g physician and as the burial-transit	edical		<b>_</b> d								
_	certific Iding p	Me	IF FEMALE:	23c. If yes, outcome	of programs					150		
Вох	leath certi attending I for use a	ian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal de	eath 3	Ectopic pregnancy Other (specify)			2	3d. Date of delive Month	very Day Year
P.O.	the d	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknown	time or dear	5	Other (specify)					
	s that the de ned by the s detached i	by Ph	Part II. Other significant conditions	contributing to death be	ut not resultii	ng in the un	iderlying cause give	en in Part I.	23e. Did t	obacco us	se contribute to	the cause of death?
Division or Vital Records,	The law requires that the death ate has been signed by the atten bage 2 should be detached for u	q pa							1 🗆 '	Yes 2-	<b>#</b> No 3□ Pro	bably 4 ☐Unknown
oce	law re as bee	Completed							24a. Was		24b. Were aut	opsy findings available
Œ		mo.							autor perfo	rmed? 2 No	death?	ompletion of cause of 2 □ No
/ita	Physician: Th r this certificate ral director, pag	Be (	25. Was case referred to medical examiner?					26. Place of De	ath (Check only o			
7	Y is is	P	1 ☐ Yes 2 € No		nt 2 ER			4 Nursing I	Home 5□Resid	dence 6	□Other (Speci	fy)
E C	ing F After unera	ü	27. Manner of Death 1 → Natural 5 → Pending	28a. Date of Inju (Month, Day	ry 28 / Year)	Bb. Time of Injury	28c. Injur Worl		28d. Describe I	how injury	occurred	
<u> S</u>	Attending or death. ector: After by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be		ırv - At home	farm stre		Yes 2 □ No	28f Location /	Ctmot o and	Alumbosos Du	al Davida Alverba
<u>≥</u>	after after I Direct	Certification:	4 ☐ Homicide determined	building, etc	c. (Specify)	, 141111, 5116	set, lactory, office		City or Tox			al Route Number,
	To the Hospital or Attending Ph within 24 hours after death.  To the Funeral Director: After th completely filled in by the funeral	Medical C	29a. Certifier (Check only one)	nysician: To the best of niner: On the basis of and manner sta	examination	edge, death	occurred at the tir	ne, date and plac pinion, death occ	ce, and due to the curred at the time,	cause(s) a	and manner as place, and due	stated. to the cause(s)
	To th within To th	Me	29b. Signature and title of certifier				29c. License	number		29d. Date	signed (Month,	Day, Year)
			•	-		>		03757	2	Dec	cember	8007,75
2	wit	-	30. Name and address of person who	completed cause of de								
21				MD S			st. Re	storstem	MD		21136	
	Sta	te ar	31. Date filed (Month, Day, Year)	32. Registra	ar s Signatur	done	8					

Please Type of Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** WOODROW WILSON GOODMAN /Medical 4650PM 30 Z003 December 4a. Facility Name (If not institution, give street and number) Examiner 4c. County of Death 4b. City, Town, or Location of Death DOCTORS COMMUNITY HOSPITAL LANHAM PRINCE GEORGE'S 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) APRIL 28, 1916 9. Birthplace (State or Foreign 1 XM 2 ☐ F Director 215-03-7225 Yrs. 92 MARYLAND Usual Residence of Decedent 10a. State 10b. County 28a-f show 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director MARYLAND QUEEN ANNE'S 1 ☐ Yes 2 No QUEENSTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 109 WYE ACRES items 23a Funeral 21658 UNITED STATES 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces: 1 Mayes 2 □ No If Yes, Give Year or Dates: 1945–1946 Black, White, etc. 1 ☐ Never Married 2 X Married ≥ 1 ☐ Yes 2 🛣 No Specify: 3 Widowed 4 Divorced Specify WHITE Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) a d 8 SALESMAN COMMERCIAL SALES other traumatic event, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) be CRIDLIN GOODMAN ٥ PEARL DAY 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health ar 27 SHIRLEY HENRY/DAUGHTER 109 WYE ACRES, QUEENSTOWN, MARYLAND 21658 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages Department of Important: If it any injury or o 20c. Location - City or Town, State JANUARY 6 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MT ZION CEMETERY HIGHLAND, MARYLAND 2009 21. Signature of Euneral Service Licensee 22. Name and Address of Facil FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MARYLAND 21619 23a. Part1. Enter the disease, or complication hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Respiratory /Medical Due to (or as a consequence of) Examiner phic Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). physician and the burial-transit enal Due to (or as a consequence of) Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy 1 ☐Yes 2 ☐ No 5 ☐ Other (specify) Day Month detached Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? é Completed 1 ☐ Yes 3 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 1 ☐ Yes 2 🗆 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1☐Inpatient 2☐ER/Outpatient 3☐DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Director: 2 Accident investigation 1 ☐ Yes 2 ☐ No. 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alemu 8118 Goodluck RD LANHAM, MD Fasil 32. Registrar's Signature State Registrar Jake

Drivit 17 Rev 1/2001

OODROW

2121

Baltimore,

Division of Vital Records, P.O. Box 68760

	State of Maryland / Department of Health and Mental Hygiene															
	For State		State	of Ma	ryland	•	artmer <i>rtificat</i>			and N	/lental I		- m	0.8	1,31	.57
	Registrar						lillicat	e or i	Deain				No2 ()	00	40'	+ 0 1
	1. Decedent's Name	e (First, Middle,	Last)				Date of Death     Month					Death	Day	Year	3. Time o	of Death
an cal	Mary Quin	n Garne	r				,				Dece	ember	25,			$\mathbf{A}^{M}$
er	4a. Facility Name (h	f not institution,	give street and nu	ımber)			4b. City,	Town, o	r Location	of Death			4c. Count	y of Death		
	3136 Harn	ess Cre	ek Road				Annapolis						Anne Arundel			
0	5. Social Security N	lumber 6	. Sex	7. Age	(In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)					ar)	9. Birth	place (State ntry)	or Foreign			
	185-07-24	57	1 □ M 2 XX	M 24 F 91 Yrs.   Months Says   Dec. 2, 1917   P						Penn	sy1var	iia				
	Usual Residence of	Decedent														
	10a. State 10b. County 10c. City, Town or Location								10d. Inside (							
ctor	Maryland	rundel		Anna	polis	S								XX Yes	3 2 □ No	
jre.	10e. Street and Nur	mber	-				10f. Zip	Code				10g.	Citizen of	What Cou	ntry?	
la [	3136 Harn	ess Cre					403					nited	Stat	es		
ne	11. Marital Status	orces?	ver in U.S	3. 13.								ace - American Indian, ack, White, etc.				
Z Z	1 Never Marri						1 □Yes XIX No Specify:					Specify: White				
d D	3 <b>X</b> Widowed		16a. Decedent's Usual Occupation 16b. Kind of Busin							2	1 -1					
ete	(Spec	Education grade completed)	)		(Giv	edents Usu e kind of wo DO NOT u	rk done	during mos	st of work	ing	160	o. Kind of t	ousiness/ir	austry		
Completed by Funeral Director	Elementary/Secondary (0-12) College (1-4or 5-					mo.			hnici	ian		U.	S. Na	avy C	ivilia	ın
Be C	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)										me)					
To B	Martin Qu				Mary	Chr	ist									
-	19a. Informant's Na	ame/Relationshi		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Sta							n, State, Zi	p Code)				
	Anne D. G	Garner /	Daughte	r		2500 Wisconsin Ave NW Apt. 608 Washington DC 200							007			
	20a. Method of Dis				20b. Pla	20b. Place of Disposition (Name of cemetery, crematory or other place)  Date 20c. Location					- City or T	own, State				
	XX Burial 2 l 4 ☐ Donation	☐ Cremation 3 5 ☐ Other (Spe	B □ Removal from ecify)	State						2/30	)/2008	Da	vidso	onvil	le, Ma	rylan
	21. Signature of Fu	ineral Service Li	censee			2	22. Name a	nd Addre	ss of Facili	ty Jo	ohn M.	Tay	lor I	uner	al Hom	e,Inc
	Me	hel Le	llan			1	47 Du	ke c	f Glo	ouces	ster S	t. A	nnapo	olis,	MD 21	401
	23a. Part 1. Enter t	the disease, or c	omplications that	caused line	the death.	. Do not er	nter the mod	de of dyi	ng, such as	cardiac	or respirato	ry arrest			Approxima Interval Be	etween
	Immediate Cause disease or condition	(Final	,	Ar	OV	70 V	ia								Onset and	Reath
	resulting in death)	1	Pa Due to	(or as a	consequ	ence of):		-							700	mys.
			h	AI	ze	Fhn	rers	L	)en	ner	tia				100	15.
ner	Sequentially list co- if any, leading to im	nditions, nmediate	Due to	(or as a	consequ										,	J
Examiner	cause. Enter Unde Cause (Disease or that initiated events	injury	c													
EX	resulting in death)	Last	Due to	(or as a	consequ	ence of):										
<u>@</u>			A													

**Physician** /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlansit one pletely filled in by the funeral director, page 2 should be detached for use as the burlansit

Medical Certification: To Be Completed by Physician/Medic

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

υ.	Due to (or as a consequ	ie
C.		
	Due to (or as a consequ	ie
d.		

23c. If ves, outcome of pregnancy	
1 ☐ Live birth 2 ☐ Fetal dea	
4 Pregnant at time of death	5 □ Other /s

pregnancy specify)

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death?

9 Unknown

23b. Was decedent pregnant

in the past 12 months? 1 ☐ Yes 2 ☐No

IF FEMALE:

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

9 Unknown

1 ☐ Yes 2	□ No
24a. Was an autopsy performed?	24b.
1 DVa a 2 No	

28d. Describe how injury occurred

5 Residence

26. Place of Death (Check only one)

Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No

Year

25. Was case referred to medical examiner? 1 ☐ Yes 2 **N**No 27. Manner of Death 1 🖪 Natural

29b. Signature and title of certifier

1 Inpatient 28a. Date of Injury (Month, Day, Year) 5 Pending investigation 6 Could not be determined

3 DOA 2 ER/Outpatient

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

D0040904

💌 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one)

2 Accident

3 Suicide

4 Homicide

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29d. Date signed (Month, Day, Year) 29 12 2008

30. Name and address of person who completed cause of death (tem 23a) (Type, Print)

Dr. Nancy Rivera-King L.L.C. 1209a Marda Lane Annapolis, Maryland 21403

31. Date filed (Month, Day, Year)
DEC 3 0 2008

L.C. \_\_\_\_ Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Registrar

State

uanita Hallowanç	1	amend # State of Maryland 7 Department of Health I-For State Certificate of Death Registrar		Reg	. No. 200	8 4345
Physiciai Nedical Examin	or.	1. Decedent's Name (First, Middle,Last)	<i>x</i> *	2. Date of Death Month December 2	Day Year 23 2008	3. Time of Death 1901 hrs
	ı	4b. City, To Montgomery General Hospital  4b. City, To Olney	wn, or Location of Death		4c. County of Death	
Funeral Director		5. Social Security Number 6. Sex 1 M 2 F		2 pate of Birth 5 / 16 / 1	(MM/DD/YYYY) 9. Bir	rthplace (State or gn puntry)LIBERIA
Maryland 28a-f show any: d at once.		Usual Residence of Decedent  10a. State				10d. Inside City Limits 1 X Yes 2 No
th the Maryls 23a or 28a-F notified at o	al Director	the state of the s	Code  8 6 0 t of Hispanic Origin? ( S	U	SA	intry?
after death wi	by Funeral	1 X Never Married 2 Married Armed Forces? If Yes, specify 1 Yes 2 X No If Yes, Specify 1 Yes 2 X No If Yes	Cuban, Mexican, Puerto  No specify:	Rican, etc.)	White, etc.  Specify: BL	ACK
36 in 72 hour han "natu	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  3	occupation (Give kind of ing life. DO NOT use ref		16b. Kind of Business.	y 24 Months
21215-0036 Buld be filed within 7 Mental Hygiene. marked other than	Be	17. Father's Name (First, Middle, Last)  U  19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address	nk VICTO	e (First, Middle, Ma RIA WIL Rural Route Numb	aiden Surname) LIAMS	
re, MD 2  I and 2 shoul Health and N  Fitem 27 is n er traumatic	ř	VICTORIA WILLIAMS/MOTHER 18020 BRA  20a. Method of Disposition 20b. Place of Disposition (Name			· ·	MD 20860 r Town, State
Baltimore, MD pennit, Pages I and 2 sho De sartment of Health and Important: If item 27 is injury or other traumat	- 1	4 1 Donation 5 Other Specify: GATE OF HEAV 21. It plature of Funeral Service Lio insee	Address of Facility	CAPITOL	SILVERS MORTUAR	Υ
Physician		23a. Part I. Enter the disease, or complications that caused the death. Dimot enter the mode of failure. List only one fause on each line.  Immediate Cause (Fin isease or condition resulting in death)  Thus to (or as a consequence of):	MARY LAND	AVE., N or respiratory arres	. E . WASH st, shock, or heart	Approximate Interval Between Onset and Death
ed Issit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):				
execus an and al - tra	edical	d. UNPENDED AMENDED				
Box 68760, he death certificate be the attending physici the direction of the burning the	sician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 ✓ Unknown  2  Fetal death 4  Pregnant at time of death 5  Other (Spec.	3 Ectopic pregr	nancy	23d. Date of delive Month	ry Day Year
	ed by Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying	cause given in Part I.			o the cause of death?  obably 4  Unknown  autopsy findings available
Recc The laricate ha	Completed		6.Place of Death (Checl	autops perforr 1 <b>V</b> Yes 2	y prior to ned? death?	completion of cause of
of Ving Physical Colores of the colo	ition: To Be	examiner? 1 Ves 2 No  1 No Pending  1 Natural 5 Pending  1 No Pospital: 1 Inpatient 2 FR/Outpatient 3 DO Pospital: 2 No Pending No P	Othor	ing Home 5 F	Residence 6 Oth	er:
hou ner y fil	l Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) Parking Lot 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the		or Town, St 18028 Loganbo	ate) erry Circle, Olney, I	
Fo the Evithin 24	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my and manner stated.	opinion, death occurred	at the time, date a	and place, and due to	the cause(s)
	Ž	Theolen M. King JA, wis.	O.C.M.E. 0	CME	29d. Date signed (M December 24, 2	
R2		30. Name and address of person who completed cause of death (Item 23a)  Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Pe	nn Street, Baltimo	re, MD 21201		
Sta Registi	ate rar	31. Date filed (Month, Day, Year) DEC 3 1 2008  32. Registrar's Signature				
DHMH 17 Rev 1/20		ORIGINAL				-

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First Middle, Last) Day Year **Physician** Sennia Haile 28 2008 Dec 11:55p /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 6711 Central Avenue Capitol Heights Prince George's 8. Date of Birth (Month, Day, AUG. 25, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthdav) 5. Social Security Number 6. Sex **Funeral** Hours 1 □ M 2 1 F Days Year Yrs Tennessee Director 411-86-3452 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f show 1 XYes 2 No Director Prince George's Capitol Heights 10e. Street and Number 10g, Citizen of What Country? items 23a 6711 Central Avenue 20743 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 \_\_Yes \_ 2 \_\_XNo 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married "natural", or If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: Black Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be flied within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Mental traumatic contractions. Elementary/Secondary (0-12) College (1-4or 5+) Domestic Private vrs 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be J. B. Dave Emma E. Gilbert ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Central Avenue Capitol Heights, Maryland 20743 <u>Mahari Haile/Husband</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Riverdale Crematory | 12/31/2008 Riverdale, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses J. B. Jenkins Funeral Home 7474 Landover Road Landover, Maryland 20785 23a. | art |. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Metastatic Breast Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physiclan: The law requires that the death certificate be executed and Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 21 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☑ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 PResidence 6 Other (Specify) 1 ☐ Yes 2 🖾 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 🔀 Natural 5 Pending death. 1 ☐Yes 2 ☐ No investigation after death 2 Accident the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a 29a. Certifier Medical 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: So the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

M\_5

Baltimore, Maryland 21215-0036

P.O. Box 68760

Division of Vital Records,

State 31. Date filed (Month, Day, Year)

Registrar DEC 3 1 2008

Nader Tawakoli 4000 Mitchellville Road # A312 Bowie, Maryland 20716
led (Month, Day, Year)

32. Registrar's Signature

C 3 1 2008

39. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D41978

December 30, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2008 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician DECEMBER 29, 2008 11:50 MPN MARGARET IDELL HOLDER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner REEDERS MEMORIAL HOME BOONSBORO WASHINGTON Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral**  Date of Birth (Month, Day, Year) 1 ☐ M 2 🔀 F Months Days Hours Director <u> 216-14-6655</u> MARCH 10,1922 MARYLAND Usual Residence of Decedent r 28a-f show notified at 10a. State 10c. City. Town or Location 10b. County 10d. Inside City Limits 1 ∑Yes 2 □ No Completed by Funeral Director MARYLAND WASHINGTON BOONSBORO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 27 Is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be U.S.A.

14. Race - American Indian,
Black, White, etc. 141 SOUTH MAIN STREET 21713 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🙀 No Specify: 3 Widowed 4 ☐ Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and 2 should be filed within 'lealth and Mental Hygiene. m 27 Is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) 8 HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ JOHN WILLIAM THOMPSON MARTHA ELIZABETH HOLDER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 i GEORGE W. HOLDER/SON 4007 CHESTNUT GROVE ROAD, KEEDYSVILLE, MD other 1 Pages 1 ment of H 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Qther (Specify) BROWNSVILLE HGTS. CEM 1/2/2009 BROWNSVILLE, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility BAST-STAUFFER FUNERAL HOME KeÍly A. Zimmerman 7606 Old National Pike, Boonsboro, MD 21713 , or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. P rt1. Into the dissession shock, the eart failure. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) preterrorea days /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician Physician/Medical as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 ☐ Yes 2 ☐ No Other: 2 ER/Outpatient 3 DOA Certification: To 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No. neral Director: / / filled in by the f 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a

To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 12/30/08 03251 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DR. ROBERT GUEDENET 21 WYAND DRIVE, KEEDYSVILLE, MARYLAND ()H-1 21756 301-432-2222

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

DEC 3 1 2008

32. Re

strar's Signature

5-0036

2121

Maryland

Baltimore,

Division or Vital Records, P.O. Box 68760,

State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Year Hull December Lennis Junior 28 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Washington County Hospital Hagerstown Washington | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Month, Day, | Min. | April 3, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F 217-32-6257 71 Director 1937 Marýland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, I'm Medical Examment on other traumatic event, I'm Medical Examment on the permitting at Director 1 ☐ Yes 2 ☐ No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9728 Garris Shop Road 21740 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, If Yes 2 No
If Yes, Give
Year or Dates: 1955-1959 2 □ No 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗙 No Specify 2 Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cutter Mfg Rain Coats 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward Clarence Hull Purdham Lula Bell 0 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martha J. Hull Wife 9728 Garris Shop Road, Hagerstown, Md. 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Rose Hill Cemetery 01-03-09 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown, Marvland 21. Signature of Funeral Service Licenese Andrew K. Coffman Funeral Home, Inc. R hoel Braa 40 East Antietam Street, Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** METRIMATI Reno disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) ed by the a 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Ωe perdeni 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown icate has been sig ; page 2 should b Completed ver 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate performed' ONICE 95 1 ∐ Yes 1 ☐ Yes 2 ☐ No 2 40 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this After th funeral 27. Mann Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural n 24 hours after death.

Reference of the following the fo death. 1 ☐ Yes 2 ☐ No 2 Accident ☐Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 hor To the Fune completely fi (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Degreel mund 2008 1006111 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) e(5 00 DH-10+1 1) ani ancisco 32. Resistrar's Signature 31. Date filed (Month, Day, Year) State DEC 3 0 Registrar

arry Clayton Hard	1-	- For State Certificate of Dea		Hygiene	No. 200	18 4346
Physician/	1	1. Decedent's Name (First, Middle,Last)  Harry Clayton Hardy, Jr.		2. Date of Death Month December 2	11 100	3. Time of Death
Medical Examine			Town, or Location of De		4c. County of Deat	
		7 1110 7 1110 1110 1110 1110 1110 1110	apolis		Anne Arundel	
Funeral Director		5. Social Security Number 218-14-2115 6. Sex 7. Age (In yrs. last birthday) If Un Mon	der 1 Year If Under 24 ths Days Hours	Min. 08/11,	/1922 Forei	mMaryland buntry)
any.	_	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
<b>*</b>	5	MD Anne Arundel Severna Par				1 Yes 2 X No
the Maryland a or 28a-f sho offfed at once.	מובנו	10e. Street and Number 208 Kathleen Avenue	21146	10g	. Citizen of What Cou USA	intry?
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland than Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f she unatic event, the Medical Examiner must be notified at once To'Re Computed by Funeral Director		1 Never Married 2 Married Armed Forces? If, Yes, spe	dent of Hispanic Origin? cify Cuban, Mexican, Pu		White, etc.	nite
5-0036 ed within 72 hours aft ed within 72 hours aft other than "natural" the Medical Examine			al Occupation (Give kind vorking life. DO NOT use		6b. Kind of Business Plumbin	
21215-0036 uld be filed within 7 Mental Hygiene, marked other than e event, the Medica		17. Father's Name (First, Middle, Last)  Harry Clayton Hardy, Sr.	Anna	Name (First, Middle, Ma Beatrice I	ill	
MD 2121 3 2 should be fi th and Mental 27 is marked numatic event,	2 ]	Patricia Hardy/ daughter P.O. 308	SS (Street and Number 1422 St. Tho	omas, VI 00	er, City or Town, Stat 1803 20c. Location - City of	
Baltimore, M permit. Pages I and 2 Department of Health Important: If iten 2 injury or other traun	1	20a. Method of Disposition  1 Burial 2 X Cremation 3 Removal from State  4 Donation 5 Other Specify:  20b. Place of Disposition (No crematory or other plan Metro Cremat	ce) L	Dec. 30, 2008		e, Maryland
Balti permit. Departi Importi injury	1	21 9 nature F eral Service Licepoee 495 GC				uneral Home MD 21146
Physician 'Madical aminer		23a. P. ft I. Enter the disease, or complications that cause the death. Do not enter the modaliure. List only one cause on each line.  Immediate Cause (Final disease  a. Atherosclerotic Cardiovascular Disease	e of dying, such as card	liac or respiratory arres	t, snock, or neart	Approximate Interval Between Onset and Death
· American		or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions,  b.				
		if any, leading to immediate Due to (or as a consequence of):				2 **
uted nd nd ransit		(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  d.				
be executed sician and urial - transit	alcal	UNPENDED AMENDED				
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transition of the contraction of t	sician/i	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 5 Other (S		regnancy	23d. Date of delive Month	Day Year
O. B. at the de laby the tached f	힌	Part II. Other significant conditions contributing to death but not resulting in the underly	ring cause given in Part			o the cause of death?
S, P.	a pe	Diabetes mellitus				obably 4  Unknown
Division of Vital Records, P.O. B pital or Attending Physician: The law requires that the doors after death.  Retal Director: After this certificate has been signed by the filled in by the funeral director, page 2 should be detached.	Completed			24a. Was al autops perforr 1 Yes 2	y prior to ned? death?	completion of cause of
ician:	a l	25. Was case referred to medical examiner?  Hospital: 1 Inpatient 2 FR/Outpatient 3	26.Place of Death (C		Residence 6 Oth	er:
n of Viding Phys. h. After this	0U: 10	27. Manner of Death  1 Ves 2 No  28a. Date of Injury (Month, Dey, Year)  28b. Time of Injury	28c. Injury at Work?	28d. Describe h	ow injury occurred	
Divisior all or Attend as after death at Director: led in by the	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specific)	ory, office building, etc.	28f. Location (S or Town, St		Rural Route Number, City
Division  To the Hospital or Attent within 24 hours after death the Funeral Director: completely filled in by the	edical Ce	29a. Certifying Physician: To the best of my knowledge, death occurred at one)  Wedical Examiner: On the basis of examination and/or investigation, in	the time, date and place my opinion, death occu	e, and due to the cause irred at the time, date a	e(s) and manner as st nd place, and due to	ated. the cause(s)
To viii	ĕ⊦	and manner stated, 29b. Signature and title of certifier	29c. License number		29d. Date signed (A	•
Tox\ \		Dr. mointins	O.C.M.E.		December 27,	2008
1,200			nn Street, Baltimor	e, MD 21201		
Star Registra	te	31. Date filed (Month Day Sea) 2008 32 Registrar's Signature	/			
Ved Service	الت	V				

DHMH 17 Rev 1/2001 OCME 2006

			For State Registrar	State of	Maryland	•	artment rtificate			and Me		ene g. No 2 (	008	431	463
	Dhusisi	Ä	1. Decedent's Name (First, Midd	lle, Last)						2	2. Date of Death Month		Year	3. Time o	f Death
	Physici /Medio			Harold L.		eper					ecember	30,	2008	6:00	р М
1	Examin	er	4a. Facility Name (If not institution	, 3	,				Location o			4c. Cou	nty of Death	_	
			Calvert Manor  5. Social Security Number		e Cente '. Age (In yrs. Ia		If Under		g Sun		B. Date of Birth		Ceci		- U Continu
Е	Funeral Director		167-14-2916	1 M 2 □ F	. Age (III yrs. ie	Yrs.	Months	Days	Hours	Min	(Month, Day,	Year)	0 Penn	olace (State	or Foreign
Sam	-		Usual Residence of Decedent								.00. 13	172	o reilli	syrvar	ııa
	yland now at		10a. State 10b. County	у	10c. City,	, Town or Lo	cation						1	10d. Inside C	•
	e Mar a-f sl	cto	Pennsylvania	Lancaster	1			Not	ttingl	ham				1 🗌 Yes	2 No
	ith the	Dire	10e. Street and Number				10f. Zip				10	g. Citizen	of What Cou	ntry?	
	ath w	Funeral Director	1345 Lloyd Ro					193					U.S.A.		
	er de items	inne	11. Marital Status 1 □ Never Married 2 □ Ma	Armed Fore		5. 13.	was Deced If Yes, spec	ent of Hi city Cuba	ispanic Origin, Mexican	gin? (Speci i, Puerto Ri	ty Yes or No- can, etc.)		Race - Americ Black, White,		
36	rs aft	by F	3 Widowed 4 □ Divorce	If Yes Give	9		1 ☐ Yes 2	No X	Specify:			Spe	ecify: Wh	ite	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by	15. Decede	nt's Education		16a. Dece	dent's Usua	l Occup	ation		1	6b. Kind o	f Business/In		
215	within 7; ene. than "n he Medi	ple	(Specify only high) Elementary/Secondary (0-12)	est grade completed) College (1-	4or 5+)	life.	kind of wor DO NOT us	rk done d se retired	during most I)	t of working	'				
21	yd wit ygien er the	Son	Eight Years				Catt	le I	Dealer				ricult	ure	
pu	be file tal Hy d oth	Be	17. Father's Name (First, Middle						18. Mothe	r's Name (	First, Middle, N	laiden Suri	name)		
yla	should be introduced that we wanted of the umarked	မ		in Housekee	per	I					rgaret				
Maryland	12 sh h and 7 Is m rraum		19a. Informant's Name/Relation				-				Route Number,	•		,	
	1 and Healt em 2		Larry Houseke	eeper	20b. Pla	ace of Dispo	sition (Nam	ne of	i	Dat	gham, P		Ivania on - City or To		52
Baltimore,	ages nt of t: If It		1 X Burial 2 ☐ Cremation		tate Ce	emetery, crei Little	matory or ot B <b>ri</b> t	therplac ain	1	01/0		Ful	ton To	wnshi	)
臣	permit. Page Department Important; If any Injury of once,		4 Donation 5 Other ( 21. Signature of Funeral Service		Pres	sbyter	ian C	emet	ery!	01/03		Pe	nnsylv	ania	
Ba	permi Depa Impo any I		& how El. D	1 /21/180	DEN T	$\langle C   \frac{1}{2}$	ee A.	Pat	terso	ón & S	Son Funda	eral 1	Home,	$P_{\bullet}A_{\bullet}$	
	F 5-58		23a. Part1. Enter the disease, of	or complications that ca	used the death.	_							0	Approxima	te
	Physician		shock, or heart failure. Lis Immediate Cause (Final	st only one cause on ea	ch line.	000	7							Interval Be Onset and	Death
9	/Medical		disease or condition resulting in death)	a. Due to (c	r as a consequ	ence of):									
	Examiner		Commentation link and distance	b		Dein	enti	a							
	p #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (c	r as a consequ	ence of):									
	ate be executed hysician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C	r as a consequ	ones of):									
8760,	be ex ician burial	ical E		Due to to	as a consequ	ence ory.									
687	requires that the death certificate een signed by the attending physi nould be detached for use as the	S S S		d											
Box (	certii nding use a	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outc								23d.	Date of deliv	erv	
	death e atte	iclaı	in the past 12 pronths?	4□Pregna	rth 2□Fetal int at time of de		∃Ectopic pre ∃Other <i>(sp</i> e						Month		Year
P.0	t the by the	hys	9 □ Unknowh	9□Unkno	wn										
	e law requires that the death certifics has been signed by the attending ph je 2 should be detached for use as t	Completed by Physician/Med	Part II. Other significant condit	tions contributing to dea	ath but not resul	Iting in the u	1 4	ause give	en in Part I.			3.7	ontribute to t	he cause of	death?
ord	equir sen si ould b	bel		GERDIT	00.		10 C	-740	- ***		1 ☐ Ye	s 2 <b>X</b> IN	o 3□ Prol	bably 4 🗆	Unknown
ecc	aw Is b	ple		MO CVA							24a. Was an	, I	b. Were auto	opsy findings impletion of o	available cause of
H H	Th ate pag	Som		h/o PVD	•						perform 1□ Yes 2	ed? No	death? 1 ☐ Yes	2□ No	
/ita	sician; Th certificate rector, pag	Be	25. Was case referred to medic examiner?	al Hospital:				045			Check only one			_	
or	Physical this call direction	မ	1 ☐ Yes 2 No 27, Manner of Death	1 □ In 28a. Date o	patient 2 E	P/Outpatier 28b. Time o			4 EL NU		e 5 ☐ Reside			fy)	
L	ding I. After funer	ion	1 Natural 5 ☐ Pend	/8 ft - m46	n, Day Year)	Injury	M 2	8c. Injur Worl	yaı k? Yes 2∐1		d. Describe ho	w injury oc	currea		
Division or Vital Records,	Attending r death. ector: After by the funer	licat	3 Suicide 6 Could	not be 28e. Place	of injury - At hor	me, farm, str	= 1.		_		f. Location (Str	eet and Nu	ımber or Run	al Route Nur	nher.
<u>S</u>	after after Dire	erti	4 ☐ Homicide determination	buildin	g, etc. (Specify,	)					City or Town	State)			
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	Medical Certification: To	29a. Certifier 1X Certify	ing Physician: To the	est of my knov	viedge, deat	h occurred	at the tir	ne, date an	d place, ar	nd due to the ca	use(s) and	I manner as s	stated.	
	he Ho in 24 ihe Fu	edic	one)	al Examiner: On the ba and mann	er stated.					ith occurred	at the time, da	ite and pia	ce, and due t	to the cause	s)
	To 1 To 1	Σ	29b. Signature and title of certifi		·		1 29c		e number	100			gned (Month,		-
				NAWAZ 1	< HAN /	עוויי	257	Ţ	762	190		12	- 31 -	-08	
	(0		30. Name and address of perso	n who completed cause	of death (Item	23a) (Type,	Print)	(1)	TEA	25	. []	NT.	own	1001	921
	Sta	to	31. Date filed (Month, Day, Year	1+161+	gistrar's Signat	ure .	1	, ()	101	U S	1 56	1-10	J, V, 11		. –,
	Sta Registi		IAN 052		4	back	1								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #2 Per FH G8882/05/09 Jh
State of Maryland / Department of Health and Mental Hygiens Certificate of Death Reg. No 2 0 0 8 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** David Theo dore Hoffman 29,2008 11:50 Ducanbo /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Hage stown
If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Hospital 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2□ F Months Days Hours Min July 29,1953 WV **Director** Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show 27 Is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinar ir ust be nothed at Director 1 ☐ Yes 2 No Washington Hancock 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 13866 Woodmont Road permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s any injury or other traumatic event, the Medical Eventime man 21750 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 
Yes 2 
No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify. Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 Construction Inspector State Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Theodore Frederick Hoffman Edith Louise Landers 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty J. Hoffman/Wife 13866 Woodmont Road Hancock, MD 21750 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🏿 Cremation 3 ☐ Removal from State Smithsburg Crematory 01/02/2009 5 ☐ Other (Specify) 4 ☐ Donation Smithsburg, MD 22. Name and Address of Facility 141 West Main Street 21. Signature of Funeral Service License Grove Funeral Home, P.A. Hancock, MD 21750-0368 23a. Part1. Enter the disease, or complicitions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Suptic disease or condition resulting in death) /Medical Due to (or as a nsequence of): Examiner in kumon; Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 

Ectopic pregnancy in the past 12 months? Month Dav Year 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 → No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autopsy perform 1 □Yes Division of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 → inpatient 2 □ ER/Outpatient 3 □ DOA Certification: To . Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural the Funeral Director: A death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) To the I and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D65488 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pajman A. Dav 31. Date filed (Month, Day, Year) 12821 Hill Ave. Hayerstan MD Danai oak

DHMH 17 Rev 1/2001

0

State Registrar

**ORIGINAL** 

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) DEC.  $23^{ay}$ **Physician** 2008 WILLIETTE JUPITER 1520 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SPRING If Under 24 Hrs. HOLY CROSS HOSPITAL SILVER MONTGOMERY 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number **Funeral** 1 □ M 2 💢 F Months Days Hours Min 83 Yrs. Director 1025 Liberia 214-13-4935 JAN. 18 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f shov r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 1 AYes 2 No Director Wheaton Md. Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10951 Amherst Ave. 20902 Liberia Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 X No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify. Specify: Black ģ 3<sup>™</sup> Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Is marked other than College (1-4or 5+) Elementary/Secondary (0-12) Director Private permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important; If item 27 Is marked other any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Cyril W.A. Davies-Johnson Marie J.E. Bright ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10945 Amherst Ave. Wheaton, Md. 20902 Michael Jupiter / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Chesapeake Crematory | 12-30-08 Beltsville, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Capitol Mortuary, Inc. 1425 Maryland Ave., NE Wash., DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CARDIORESPIRATORY ARREST /Medical Due to (or as a consequence of) **Examiner** HYPERKALEMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I þ OBSTRUCTIVE SLEEP APNEA 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an SEVERE ANEMIA autopsy Yes 2X No 2 No 1 ☐ Yes BREAST CANCER 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 24 hours after death Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 29a. Certifier 1 Cretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D63579 Dec. 23, 2008 30. Name and address of person who completed dayse of path (Item 23a) (Type, Print) 1500 Forest Glen Road Silver Spring, Md. Maria Tayag, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signa State

DHMH 17 Rev 1/2001

Registrar

DEC 3 1 2008

			State of Maryland / Dep	partment of Health and Nertificate of Death		/ 11 11 1/	43466
			Registrar  1. Decedent's Name (First, Middle, Last)	er tiricate or Death	2. Date of Deat	g. 110.	
	Physici	an			Month	Day Year	3. Time of Death 12:00 PM
	/Medic		Nell M. King  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	Dec. 30	4c. County of Death	12.00 11
	Examin	ier	Villa Rosa Nursing Home	Mitchellville		Prince Ge	owas ta
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	() If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	9. Birth	place (State or Foreign
	Director		579-44-5064 1□M 2⊠F 94 Yrs.	Months Days Hours Min.	(Month, Day, July 14	Year) Cou	haw, SC
	P .		Usual Residence of Decedent				
	show	_	10a. State 10b. County 10c. City, Town or	cocation			10d. Inside City Limits
	Ba-f s	ç	Maryland Prince George's Laurel				1⊠Yes 2□No
	or 2	Directo	10e. Street and Number	10f. Zip Code	1	ng. Citizen of What Cou	ntry?
	within 72 hours after death with the Maryland lene. than "natural", or items 23a or 28a-f show the Modical Examirer must be redified at	a	7814 Aylesford Lane	20707		JSA	
	er de item	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	<ul> <li>Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto</li> </ul>	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White,	
36	s aft	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1 ☐ Yes 2 X No Specify:		Specify: Wh:	ito
215-003	tural			edent's Usual Occupation		16b. Kind of Business/In	
15	in 72 n "na Agdic	Completed	(Specify only highest grade completed) (Given life	e kind of work done during most of work DO NOT use retired)	ing	rop. Killa of business/in	dustry
212	with jiene	mo	Elementary/Secondary (0-12)   College (1-4or 5+)	memaker		Own Home	
	e filed Il Hygi other ent, I	BeC	17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, N	faiden Surname)	
Maryland	2 should be filed within 72 hours after death with the Marylan and Mental Hygtene. is marked other than "natural", or items 23a or 28a-f show aumatic event, if a Medical Examiner must be redified at	70 B	William Cooper	Armenta	Sanders		
ar S	s 1 and 2 should the Health and Men item 27 is marker other traumatic	-	19a. Informant's Name/Relationship (Type. Print) 19b. Ma	ling Address (Street and Number or Run	al Route Number,	City or Town, State, Zip	Code)
	and 2 ealth a n 27 is		James King / Son 7814	Aylesford Lane, L	aurel, M	ID 20707	,
ē	of He item		20a. Method of Disposition 20b. Place of Dis			20c. Location - City or To	own, State
Ĕ	Pages nent of ant: If its ary or o		Total 2 Defination 3 Differnoval from State		/2009	Washington,	DC
altimore,	permit. Pages Department of Important: If it any injury or o			22. Name and Address of Facility	4005		
ñ	Per E Per		4007#	asch's Funeral Hom	e. P.A.	4739 Baltin	nore Avenue
П			23a Part 1. Enter the disease, or complications that caused the death. Do not e				Approximate Interval Between
	Physician		shock, or heart failure. List only one cause on each line.	otic Candio Vasc	1.	Carre	Onset and Death
	/Medical		disease or condition resulting in death)  a. Due to (or as a consequence of):	one con ono vosc	man p	1sease	J-Pars
	Examiner		De monte	Eq			4-0-118
	D +	ner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				Jeans
	nd ransi	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	athy		-	y-pars months
Ď,	e exe ian a urial-1	E	resulting in death) Last Due to (or as a consequence of				
8/60	icate be executed physician and the burial-transit	dical	<b>L</b> d				
٥	certific	Mec	IF FEMALE:				
ž RO RO	e law requires that the death certifi has been signed by the attending ie 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	☐ Ectopic pregnancy		23d. Date of delive	*
5	the a	sici	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5	Other (specify)	<u> </u>	Month	Day Year
7.	d by etacl	Phy			00 01111		
Š,	res ti signe be d	þ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		acco use contribute to the	
Sora	requ	ted			1 □ Ye	s 25 No 3 □ Prot	pably 4 Unknown
ec S	e 2 sl	Completed			24a. Was an autopsy		psy findings available mpletion of cause of
_	: The	Co			perform	ed? death?	2 🗆 No
VITA	ician Sertifi ector	Be	25. Was case referred to medical examiner?	26. Place of Death	(Check only one		
5	Phys this at dir	၉	1   Yes 2   No   Hospital: 1   Inpatient 2   ER/Outpati			nce 6 ☐ Other (Specif	y)
	ting 1. After funer	io	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time Injury	Work?	28d. Describe how	v injury occurred	
<u> </u>	ttenc death death ttor:	icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	M 1 ☐ Yes 2 ☐ No			
UNISION	or A after of Direction by	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	reet, factory, office	28f. Location (Str. City or Town,	eet and Number or Rura State)	l Route Number,
	pital purs a eral filled		29a. Certifier TV Certifying Physician: To the best of my knowledge dea	Ab accounted at the time data and also		()	
	To the Hospital or Attending Physician: The law requires that the death within 24 hours after death.  To the Luneral Director: After this certificate has been signed by the attent completely filled in by the funeral director, page 2 should be detached for u	edical	29a. Certifier (Check only one) (Check only one) (Check only one) (Check only one)	nvestigation, in my opinion, death occurr	and due to the ca ed at the time, da	use(s) and manner as s te and place, and due to	tated. the cause(s)
	o the	Me	29b. Signature and title of certifier.	29c. License number	29	d. Date signed (Month,	Day Year)
•	F S F O						
	05		30. Name and address of person who completed some of death (New 20.) (7)	Drint	0	12/3/10	΄ δ
7	120		30. Name and address of person who completed cause of death (Item 23a) (Type RAKESH ARURA, MD 143	OGGALLANTFO	XLN,	BOWIE MD	20715
	Stat		31. Date filed (Month, Day, Year) 32. Registrar's Signature		- 1		
	Registra		DEC 3 1 2008 Seem by Sparke				

17. Father's Name (First, Middle, Last)

**Physician** 

/Medical

Examiner

Funeral

Director

28a-f shov

ō

or items 23a

"natural"

other than

and Mental

permit. Pages 1 and 2 s Department of Health a Important: If Item 27 Is any injury or other trau once.

**Physician** /Medical Examiner

or Attending Physician: The law requires that the death certificate be executed

death.

thin 24 hours a Hospital

within To the

Director:

Box 68760

P.0.

Division of Vital Records,

Directo

Funeral

þ

Completed

Be

P

Examine

Physician/Medical

2

Completed

Be

Certification: To

Medical

Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

injury or other traumatic event, the Medical Examiner must be notified at

KATHERINE GENTRY

19a. Informant's Name/Relationship (Type. Print) HELEN L. KIMBALL - WIFE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12251 ROUNDWOOD RD # 609 TIMONIUM, MD 21093

Date

20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify)

ARLINGTON NATIONAL CEMETERY APRIL8,2009 ARLINGTON, VIRGINIA 22. Name and Address of Facility DEMAINE FUNERAL HOME

21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line

520 S. WASHINGTON STREET ALEXANDRIA, VA 22314

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):	
CHI	

Due to (or as a consequence of)

Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No □Yes

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death

3 Ectopic pregnancy 4 Pregnant at time of death 9 Unknown

5 ☐ Other (specify)

23d. Date of delivery Day Month

20c. Location - City or Town, State

23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?

Onset and Death

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other:

24a. Was an autopsy performed? 1 ☐ Yes 4 
Nursing Home 5 Desidence 6 ☐ Other (Specify)

1 Yes

ZVO 1 ☐ Yes 27. Mapner of Death

1 Natural 2 Accident 5 Pending investigation 3 Suicide 6 ☐ Could not be

determined

28a. Date of Injury (Month, Day, Year) Injury

1 Inpatient 2 ER/Outpatient 3 DOA

28b. Time of

28c. Injury at Work? 28d. Describe how injury occurred

1 ☐Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated,

29a. Certifier (Check only one)

4 Homicide

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

MEUTZER 31. Date filed (Month, Date

DEC 3

10 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 43468 State of Maryland / Department of Health and Mental Hygien ? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 30, 2008 **Physician** ACember 1 Irlene Virginia Kline 1520 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Washington County Hospital Hagerstown Washington If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min 1 □ M 2 🛣 F Director 214-16-1315 March 30,1917 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show s 23a or 28a-f sho Md. Frederick Myersville 1 ☐ Yes 2 XNo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12581 Stottlemyer Rd. 21773 U.S.AFuneral items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian, Black, White, etc. 7 Is marked other than "natural", or items traumatic event, the Medical Evandance. Armed Forces?

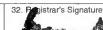
1 Yes 2 No
If Yes, Give
Year or Dates: Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: <u>م</u> 3 X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home and Mental Hygie Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ona Lewis Norman L. Draper ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23708 Foxville Rd. Smithsburg, Md. 21783 permit. Pages 1 and 2 Department of Health Important: If item 27 any Injury or other tra once. Mary Ann Stottlemyer (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 3 Jan. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Bethel Cemetery 2009 Foxville, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. algniture of Fyneral Service Licensee 22. Name and Address of Facility 12525 Bradbury Ave. J.L. Davis Funeral Home Smithsburg, Md. 21783 art / Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, now, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Intriediate Cause (Final disease or condition Phlumi **Physician** ~ 3 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Conger Sequentially list conditions, if any, leading to immediate cause. Errier underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed Arlen's Scherolie Condro Vanche burial-trar Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 4 ☐ Pregnant at time of death 5 Other (specify) certificate has been signed by the irector, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ. Vanue 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐Yes 2 ☐No To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 4No 1 Hopatient 2 ER/Outpatient 3 DOA Certification: To 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 [UNatural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the within 2 To the I and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ati MO D18019 DEC 31 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) hALERSTON N 05H-5 5 -7 MO MO 340 MILL VAJANT

State Registrar 31. Date filed (Month, Day, Year)

DEC 3 1 2008





Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 43469 1- State Amended Date, 1/05/09, WCHD, SLV Certificate of Death n's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month ÖZ /Medical -Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** If Under 24 Hrs./ 5. Social Security Number Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 60.8515 Year 1 M 2 □ F Months Days Hours Min. Director Usual Residence of Decedent 10b. County 10a. State City. Town or Location 10d. Inside City Limits show Injury or other traumatic event, the Medical Evan inserment be notified at **Funeral Director** 1 Tes 2 No 28a-f 10e. Street and Number 101. Zip Code 10g. Citizen of What Country ö US. 23a 12. Was Decedent Ever in U.S. Armed Forces?
1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: or items 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐Yes 2☐No ģ Specify: 3 Widowed 4 Divorced Blac "natural" Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nat any Injury or other traumatic event, In Material. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname) Be 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Informant's Name/Relationship (Type. Print) Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) 1,.3<sup>Date</sup>2009 Location - City or Town, State 1. Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility Bennie Smith typesal Home 917 N. Isabella ST Salisbury No 21811 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Static disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): and resulting in death) Last burial-1 P.O. Box 68760. attending physician Physician/Medical the as IF FEMALE: ves, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) the TYes 2 No. 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 25 No certificate 1 □Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: Other: 4 \sum Nursing Home 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 5 ☐ Residence 6 Nother (Specify) + OSDI ( C 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred Natural 5 ☐ Pending investigation death. 2 Accident 1 Tyes 2 No within 24 hours after death To the Funeral Director: 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 Homicide 29a, Certifie \*\*Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29b Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

311

State Registrar 30 Name

31. Date(filed (Month, Day, Year)

JAN 05

and address of person who completed cause of death (Item 23a) (Type, Print)

CLE MD
32. Registrar's Signature

	F D	unei irect	a
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Denarment of Heath and Martal Huniana	"naturel", or iteme 23a or 28a-f ehow	
£	Phy /M Exa	sicia ledic amin	ar a eı
. Box 68760,	death certificate be executed	attending physicien and of for use as the burial-transit	

			1 - State Registrar	Ce	rtificate of Death		greng 008 43470	J
	Physici /Medic		1. Decedent's Name (First, Middle, Last) James Marshall	Langley		Dec 24,	th 3. Time of Death	
	Examir Funeral Director		4a. Facility Name (If not institution, give str. Fort Washington  5. Social Security Number  5.78 34 9585		4b. City, Town, or Location of Death Fort Washington  If Under 1 Year   If Under 24 Hrs. Months Days Hours Min.		4c. County of Death Prince George's  9. Birthplace (State or Forei	ign
	Maryland f ehow	tor	Usual Residence of Decedent  10a. State 10b. County  MD Prince	George Temple			10d. Inside City Limi 1 ☐ Yes 2	
	sa or 28a-	I Direct	10e. Street and Number 6504 Morton Place	e	10f. Zip Code 20748		log. Citizen of What Country? United States	
980	within 72 hours after death with the Maryland ene. than "naturel", or iteme 23s or 28s-f ehow ha Madicel Examirer must be notitied at	Completed by Funeral Director	11. Marital Status  1 Never Married  3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces?  13. Amed Forces?  14. Yes 2 No WW II HYPS, Give Year or Dates:	Was Decedent of Hispanic Origin? (St If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes <b>2</b> (T)No Specify:	pecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hor Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature any injury or other traumatic event, tha Middiest E once.	ompleted	15. Decedent's Educi (Specify only highest grade Elementary/Secondary (0-12) 12	Completed) (Give life.	dent's Usual Occupation of kind of work done during most of work DO NOT use retired) Body Repairman	king	16b. Kind of Business/Industry  Automotives	
yland 2		To Be C	17. Father's Name (First, Middle, Last)  John Henry Lan	gley	18. Mother's Nam De	da Lyon	Maiden Surname)	
			19a. Informant's Name/Relationship (Typ: D oris Marie Lang 20a. Method of Disposition		Morton Place, Te	mple Hil		
Baltimore,	permit. Pages Department of I Important: If its any injury or o		1 ABurial 2 Cremation 3 Re 4 Donation 5 Other (Specify)  21. Signature of Fundal Service Licensee	moval from State Cedar Hi	matory or other place) 11 Cemetery 12/30	/2008	Suitland, Maryland	_
B	permit. Departr Imports any inj		23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one	A	<u>lexandria Ferry R</u>	oad, CLi	est Approximate	_
J.	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	× 1.	be Hyocardial	25	Onset and Death	
),	executed n and ial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):  Due to (or as a consequence of):	Acute Paire	mesay	ENDONSING AKER	
68760,	tificate be executed ig physicien and as the burial-transit	edical	d.	CAD STATUS	POST CABLY	PACEM	AKER	
P.O. Box	The law requires that the death certi ste has been signed by the attending page 2 should be deteched for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year	
	w requires that been signed b should be dete	þ	Part II. Other significant conditions control	ributing to death but not resulting in the u	inderlying cause given in Part I.		bacco use contribute to the cause of death? es 2 No 3 Probably 4 Ninknow	m
of Vital Records,	sician: The law requ s certificete has been lirector, page 2 shouk	Completed	Prostatil	thy per brophy		24a. Was a autops perform	prior to completion of cause of	le
f Vits	> " 0	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	spital:	Oth	th <i>(Check only on</i> ome 5∏ Reside	ence 6 ☐Other (Specify)	
Division of	tending Ph eath. or: After th the funeral	Certification: 1	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	f 28c. Injury at Work? M 1 Tyes 2 No	28d. Describe ho	ow injury occurred	
Div	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		4 Homicide determined	28e. Place of Injury - At home, farm, st building, etc. (Specify)		City or Town		
	the Hos thin 24 ho the Fun mpletely f	Medical	(Check only 2 Medical Examine one)	cian: To the best of my knowledge, deal or: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occur	red at the time, d	ate and place, and due to the cause(s)	_
	To To	-	29b. Signature and title of certifier	Kleiner M	29c. License number	62	9d. Date signed (Month, Day, Year)	
B	B441		30. Name and address of person who com Samuel J. Klei	npleted cause of death (Item 23a) (Type, man, M.D. 11711 Liv		Washingt	con, MD 20744-5164	

DHMH 17 Rev 1/2001

State Registrar

#### le.

08-09867	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legib
Jacob Daniel Lambert	State of Maryland / Department of Health and Mental Hygiene
4 F Ct t	

2	N	n	8	L	3	4	7
£	U	U	$\circ$	- 4		-1	- 8

		1- For State	Cei	rtificate of	Death		R	teg. No.	100 4041
Physicia	_	Registrar 1. Decedent's Name (First, Middle,Las	st)				2. Date of Dea		3. Time of Death
ledical Exami		Jacob Dani	el Lambert				Month December	pr 31, 2008	0943 hrs
1		4a. Facility Name (if not institution, give			b. City, Town, or	Location of Dea	_ · · · · · · · · · · · · · · · · · · ·	4c. County of	Death
		12431 Detour Road	o stroot and nambor,		Keymar	200011011 01 200		Frederick	
						Lan Land	10 D (B)		
Funeral		5. Social Security Number 6. S	, ,	last birthday)	If Under 1 Year Months Days		lin		<ol> <li>Birthplace (State or Foreign Country)</li> </ol>
Director		218-52-3512	(M 2 F 44	Yrs.		nouis iv	Mar 2	23, 1964	Maryland
		Usual Residence of Decedent							
any		10a. State 10b. County	10c. City	, Town or Locati	on				10d. Inside City Limits
A .		Maryland Freder	i ak		242	aa1			1 XYes 2 No
Maryland 28a-f show 1 at once	to		ICK		10f. Zip Code	ddletow		10g. Citizen of Wha	at Country?
Mar. 28a	Director	10e. Street and Number	1		Tot. Zip Code	24760	1	-	•
the sa or		11 East Main Stre	ÆΕ			21769		US	ρA
with	Funeral	11. Marital Status	12. Was Decedent Ever in U				Specify Yes or N		- American Indian, Black,
eath iter	un l	1 Never Married 2 Married	Armed Forces?	If Ye	es, specify Cuban	, Mexican, Pue	rto Rican, etc.)	White,	
ierd ", or		3 Widowed 4 X Divorced	If Yes, Give Year	1	Yes 2 X No	specify:		Specify:	white
Its af	ğ	15. Decedent's Education (Specify of	or Dates:	16a. Deceden	's Usual Occupat	ion (Give kind o	of work done	16b. Kind of Bus	iness/Industry
5-0036 ed within 72 hours tygiene. other than "natur	eted	Elementary/Secondary (0-12)	College (1-4 or 5+)	during mo	ost of working life.	DO NOT use r	etired)	2.3	
36 in 7.	뒴		3	Self E	mployed	Musicia	an	Mus	sic
5-0036 led within 7 dygiene. other than the Medica	Comple	17. Father's Name (First, Middle, Last						Maiden Surname)	
주 등 문 등 다	Ö	John D.S. Lambe			i		Stonesi:		
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be								
e, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f she transmatic event, the Medical Examiner must be wolffied at once	ပ	19a. Informant's Name/Relationship (						mber, City or Town	
e, MD I and 2 sho Health and item 27 is		Jonathan D. Lambe	<u> </u>					MD 21757	
		20a. Method of Disposition		Place of Dispos crematory or oth	ition (Name of cer	metery,	Date	20c. Location -	City or Town, State
more Pages I nent of H ant: If it		1 Burial 2 Cremation 3	- Ke	eysville	Union (	cem   01	/05/2009	9 Keyma	r, MD
ting the second		4 Donation 5 Other Specify	<i>r</i> :	-			200	750	neral Home
Baltimore, permit Pages I ar Department of Hee Important: If ite		1. Signature of Funeral Service Lice	isee	_			-		
7		Justin K-	Jungan					eytown, M	
Physician		Part I. Enter the disease, or com failure. List only one cause on e		n. Do not enter th	e mode of dying,	such as cardia	c or respiratory ar	rest, snock, or hea	rt Approximate Interval Between Onset and
/Medical kaminer			Asphyxia						Death
Kannner		or condition resulting in death)	Due to (or as a consequence of	of):				-	
		Sequentially list conditions, b	Hanging						
	ē	if any, leading to immediate	Due to (or as a consequence of	of):					
	Ē	cause. Enter Underlying Cause (Disease or injury that initiated					-		
sit d	Examiner	events resulting in death) Last	Due to (or as a consequence of	of):					
ecuted and transit		d	·						
e excess	ո/Medical	UNPENDED	AMENDED						
760, ficate be ex g physician the burial	ğ	IF FEMALE:	23c. If yes, outcome of preg	gnancy				23d. Date of	delivery
687 certific nding p	an/	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Fe	tal death 3	Ectopic preg	gnancy	Month	Day Year
Sox 687 leath certifi e attending for use as t	Physician		4 Pregnant at time of de	eath 5 Ot	ner (Specify)				
Box e death or the attenued for us	hys	1 Yes 2 No 9 Unknow	n 9 Unknown						
on hat the ed by etache		Part II. Other significant conditions	contributing to death but not	resulting in the L	nderlying cause g	given in Part I.	23e. Did	tobacco use contrib	oute to the cause of death?
, P.C res that signed be deta	d by						1Ye	es 2 🗸 No 3	Probably 4 Unknown
Division of Vital Records, tal or Attending Physician: The law requir rs after death.  al Director: After this certificate has been sted in by the funeral director, page 2 should take the bar tall or the funeral director.	Completed	8					24a. Was		/ere autopsy findings available
Sor law r has b	힐				<del></del>		_ auto		rior to completion of cause of eath?
Rec The Cate	6							2 <b>✓</b> No 1	Yes 2 No
tal Recian: The	Be	25. Was case referred to medical			26.Place	of Death (Che	ck only one)		
/its	8	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient	3 DOA	Other Nur	sing Home 5	Residence 6 ✔	Other: Scene
of \ing Phy	<u>۲</u>	27. Manner of Death	28a. Date of Injury	28b. Time of I	njury 28c. Inju	ry at Work?	28d. Describe	how injury occurre	ed
n of ding Pi h. After funeral	6	1 Natural 5 Pending	(Month, Day, Year)	FOUND:		Yes 2 V No	Subject for	ınd hanging	
Sio Mitten deatl	ä	2 Accident Investigat	Dec 31, 2008	0943 hrs					
Sire or A	١ĔΙ	3 Suicide 6 Could not		nome, farm, stree	et, factory, office b	ouilding, etc.	28f. Location or Town,		r or Rural Route Number, City
Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Function after death. Function after death. Function after this certificate has been signed by the attending physician and tely filled in by the functal director, page 2 should be detached for use as the burial - trans	Certification:	4 Homicide determine	(Specify) Tool Shed				12431 Detou	ır Road, Keymar,	, MD
Hos 24 ho Fun tely		29a. Certifier 1 Certifying Physic	ian: To the best of my knowled	ige, death occur	red at the time, da	ate and place, a	and due to the cau	use(s) and manner	as stated.
To the Hos within 24 h To the Fur completely	Medical	one) 2 • Medical Examine	r:On the basis of examination a	and/or investigat	ion, in my opinior	, death occurre	d at the time, date	e and place, and du	ue to the cause(s)
To To Cor	ě	29b. Signature and title of certifier	and manner stated.		29c, Licens	e number		29d. Date signe	d (Month, Day, Year)
	-	A	*		O.C.			January 1, 2	
l la		unes c				IVI. L.		Juliany 1, 2	
12 T		30. Name and address of person who				7.2			
10		Ana Rubio MD. Assista	121		street, Baltimo	ore, MD 212	201		
St	ate	31. Date filed (Month, Day, Year)	32. Registrar's Sign et	oure park	1	· -			
Regist		IANI OF 2000	Vereun D.	JEICHE					

#### State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Leola Mae Lilliston /Medical Facility Name (If not institution, give street and number, Town, or Location of Death County of Death Examiner S D UV 8. Date of Birth (Month, Day, Year) Age (In vrs. las If Under 1 **Funeral** Months Days Hours 1 □ M 2 🔀 F 137-22-6157 79 Director Dec 31,1928 Usual Residence of Decedent 10a State 10c. City, Town or Location show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is "feafest Exa, iller must burnaffied. Director MD Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 612 E. Lincoln St. 21801 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. 1 ∐Yes 2**X** No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2☐No 2 Specify: 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home Health Care Worker Healthcare 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lim Walker Essie Mae Riveria ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alverna Warrington/daughter 621 Homer St., Salisbury, MD 21804 60 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State crematory of 4 ☐ Donation 5 ☐ Other (Specify) 1/7/2009 Delmarya 22. Name and Address of Facility Lewis N. Watson Funeral Home Real Salisbury, MD 2 Delmar, (1) 21. Signature of Funeral Service Licensee 1618 West Rd., Salisbury, MD 21801 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence / f): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence on: and burial-trar Due to (or as a consequence of) physician the burial Box 68760. pe Physician/Medical as the attending IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy 5 5 Other (specify) ☐Yes 2 No o. detached 9 Unknown 9 I Unknown signed by the ď significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 M No 3 ☐ Probably 4 ☐ Unknown

of Vital Records, The law requires this certificate has been al director, page 2 should or Attending Physician: funeral After Division within 24 hours after death

To the Funeral Director: /

Completed Be Certification: To

the Hospital 2 OM

28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 X Natural 5 Pending investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 4 Homicide

stat

25. Was case referred to medical examiner?

2 No

1 ☐ Yes

29a. Certifier

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 115 PCC 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

24a Was an autopsy

1 □Yes

26. Place of Death (Check only one)

2 No

28d. Describe how injury occurred

Month

29b. Signature and title of certifier

and manner stated.

D 29505

29d. Date signed (Month, Day, Year) 12-28-2008

2008

USA

Black, White, etc

Black

Comi

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

202

Year

Day

24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No

1 Yes 2 No

30. Name and addr >s of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

M. BELLOSO, M.D.; GREGORIO 5302 CHINABERRY DR. SALISBURY, MD 21801

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State Registrar

Medical

JAN 05

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** J. Lindsay /Medical 9 2008 8:30 Barbara Dec 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner <u>Fort Washington</u> Hospital Washington Prince Georeges 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** Days Hours 1 □ M 2√□ F **Director** Washington 578**-**60-6706 29,1946 August Usual Residence of Decedent DC filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits in and Mental Hygiene. 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, <u>the Medical Examiner must be notified at</u> 1 X Yes 2 □ No Directo Fort Washington MD Prince Georges 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A 20744 <u>12425 Arrow Pk Drive</u> Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ★No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ Specify. 3 ☐ Widowed 4 ☐ Divorced black Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) <u>Administrative Assistance Government</u> 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be should be Sallie Stone ဥ Jessie Davis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Washington DC 20032 202 Malcolm X Ave. S.E. Terence Lindsay Item 27 other t 3altimore, . Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20b Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Itel
any Injury or ott 1 Burial 2 Cremation 3 Removal from State 01/12/09 | Cheltenham, MD Hodges-Edwards Funeral Home 4 ☐ Donation 5 ☐ Other (Specify) Veterans Cem 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 3910 Silver Hill Road, Suitland MD 20746 Pagt . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death maiate Cause (Final jardio **Physician** dis se or condition r ulting in death) /Medical Due to (or as a consequence of): Examiner Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner The law requires that the death certificate be executed resulting in death) Last Due to (or as a donsequence of Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ➡ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes ate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Division or Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1☐ Yes 2 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 RER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 ☐ Pending investigation Injury 1 Natural after death.

I Director: A d in by the fu 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours at To the Funeral Completely filled it Hospital 1 🖪 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) Soulm 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul Aubrey Angus Bone, 10905 Fort Washington Road, Suite 206, Fort Wash., MD 20744

) DHMH 17 Rev 1/2001

910

State Registrar 31. Date filed (Month, Day, Year)

1 5 2009

₱32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. #18 Per FH G887 1/16/09 JH State of Maryland / Department of Health and Mental Hygiene amend 1 - State Amend#1.PenPhys.PCC12-31-08 Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Willie E. Mayhand 16, 12:39p M 2008 December MAXMAND WILLIE E. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner GEORGE'S SOUTHERN MARYLAND HOSPITAL CENTER CLINTON PRINCE Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Days Year) Months Hours 1 XM 2 ☐ F 1932 Daphne, 76 17. Director 423-30-9825 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a State 28a-f show 1⊠Yes 2 No traumatic event, the Medical Examiner must be notified Director Maryland Prince Georges Forest Heights the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code filed within 72 hours after death with ō 20745 United States or items 23a 825 Quade Street Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. 11. Marital Status 1 StYes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 🔀 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced 'natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Metropolitan Police Dept. Supervisor d 2 should be filed with and Mental Hygien 7 is marked other the 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Leroy Lett <del>Macey</del> Mayhand ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2
Department of Health a
Important: If item 27 is
any Injury or other trau 20745 Louise H. Mayhand 825 Quade Street Forest Heights, Md. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Cem. 12/22/2008 Brenwood, Md. 22. Name and Address of Facility
Alexander S. Pope. P.A.
5538 Marlboro Pike/Forestville, Md. 21. Signature of Funeral Service License Alexander S Pope P A S S Marriboro Pike/Forestv rmp cations that used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nly one cause in each line. 20747 Approximate Interval Between Onset and Death 23a. Pirt 1 fill the disease, o shock, or heart failure. Lie Immediate Cause (Final disease or condition resulting in death) **Physician** CANUTIA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical 1F FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 ☐ Other (specify) signed by the a P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has t page 2 s autopsy performed? 1 ∐Yes 2 No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2⊠No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours after deat e Funeral Director: filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only and manner stated. the within 7 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D0041580 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 32. Registrar's Signature

7503 Surratts Rd.

Scott Kelso, M.D.

31. Date filed (Month, Day, Year DEC 3, 1 2008

20735

Clinton, Md.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year Albert Romayne Miller 12 2320 26 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 659 Trafalger Dr. Hagerstown Washington 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 2 M 2 □ F Months Days Hours Director 213-16-1893 89 May 25, 1919 Maryland Usual Residence of Decedent 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at any Injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 1 ☐Yes 2 No Director Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 659 Trafalger Dr. USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Completed by 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Teacher Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Albert Ragan Miller Minnie Idella Cline 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Doris E. Miller / Wife</u> 659 Trafalger Dr., Hagerstown, MD 21742 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Rest Haven Cemetery 12/30/2008 Hagerstown, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funera 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician MALNURITOR disease or condition resulting in death) WEEKS /Medical Due to (or as a consequence of): **Examiner** MOREXIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner sate has been signed by the attending physician and page 2 should be detached for use as the burial-transi JEMENTIA Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an perform 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifice Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Tyes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Naturai 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TE130 HAGERSTON USH STI 11110 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Glenn Eugene MARKS, Jr. elember 18, 30 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 723 Maryland Avenue Washington Hagerstown 7. Age (In yrs. last birthday) **Funeral** 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months 1 M 2□ F Director 65 213-40-4599 April 6 1943 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1√Yes 2□No Funeral Director Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö Items 23a permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Healtest Examiner manal. once. 723 Maryland Avenue 21740 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Folces:

1 MYes 2 No
If Yes, Give
Year or Dates: 1961-66 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 à 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Foundry Worker Sand Blasting Mfg 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ္ Glenn E. Marks, Sr. Nellie LaRue Barrow 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Penelope Marks - Wife 723 Maryland Avenue, Hagerstown, Maryland 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rose Hill Cemetery 12/31/08 Hagerstown, Maryland 22. Name and Address of Facility Minnich Funeral Home 21. Signature of Funeral Service Licenses 415 E. Wilson Blvd. Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** month resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical attending p as asn IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year 5 Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Was autopsy performe 1 □ Yes 1 ☐Yes 2 ☐ No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify) 2 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending Natural 5 Pending investigation death. 2 ☐ Accident 1 ☐ Yes 2 ☐ No To the Hospital or Attenct within 24 hours after death To the Funeral Director: the 6 ☐ Could not be 3 ☐ Suicide by 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide filled in t ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

15/1-10+1

State Registra

(Check only one)

29b. Signature and title of certifier

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

				I / Department of Health and Me	ental Hygier	ne	
			1 State Registrar	Certificate of Death	Reg. N		43477
	Physici		1. Decedent's Name (First, Middle, Last)	Morris	2. Date of Death Month	2-2008 2	3. Time of Death
· Car	/Medio		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	10 10	4c. County of Death	0.707
and the			Union Hospital  5. Social Security Number 6. Sex 7. Age (in yrs. ia:	st birthday) If Under 1 Year   If Under 24 Hrs.   8	Date of Birth	Cecil	(0)-1
ı	Funeral Director	,	3/3-42-4429 1 M 2×F 70	Yrs. Months Days Hours Min.	B. Date of Birth (Month, Day, Yea (1) 3 - 24 - 10	9. Birthplace Gountry)	e (State or Foreign
	and w		Usual Residence of Decedent  10a. State 10b. County 10c. City,	Town, or Location		100	Inside City Limits
	Maryli a-f sho	ţċ	MD Cenil El	Kton		100.	1 X Yes 2 □ No
	or 288	Director	10e. Street and Number	10f. Zip Code		Citizen of What Country?	,
	eath w	Funeral	314 Friendship Koad  11. Marital Status  12. Was Decedent Ever in U.S.	2/92/		15 A 14. Race - American	Indian
ပ္	or iten		1 Never Married 2 Married Armed Forces? 1 Yes 2 No	13. Was Decedent of Hispanic Origin? (Speciff Yes, specify Cuban, Mexican, Puerto Ri 1 □ Yes 2 ☑ No Specify:	can, etc.)	Black, White, etc.	i i
21215-0036	hours tural",	ed by	3 💢 Widowed 4 Li Divorced Year or Dates:		101	Specify: Blace	<i>l</i> c
215	hin 72 9. an "nat	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-49f 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of working tie. DO NOT use retired)	166.	Kind of Business/Indust	ry
	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ent, it a Meckel Eventher routite in tilled at		8 N/A	Domestic	4	rivate	
anc	d be fi ental H ked ot Ic ever	To Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (	First, Middle Maide	(	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural"; or items 23a or 28a-f show any injury or other traumatic event, it is Mackel Eventhar must be neathed any once.		19a. Infermant's Name/Relationship (Type. Print)	19b. Mailing Address (Street and Number or Rural I			de)
	1 and 2 Health em 27 ther tr		20a, Method of Disposition 20b, Pla	TOUT TOUT	on. Mar	ryland o	21921
altimore,	Pages nent of a ant: If ite		1 № Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	ce of Disposition (Name of petery, crematory or other place)	Ch	Location - City or Town,	State Ly
a ≣	permit. Pag Department Important: I any injury c		21. grature Funeral Service Ice Fee	22. Name and Address of Facility	100 114	P.O. Box 2	593
m ==	9 7 E 8 9	U II	Cheres emgapt	- CONGO Funeral H	tome a	Vilmington	DE19805
4	Dhusisian	8 7	23a. Part1. Enter the disease, or complications that auxed the death. shock, or heart failure. List only one cause on each line.  Immediate Cause (Final	Do not enter the mode of dying, such as cardiac or n	espiratory arrest,	Inte	proximate erval Between set and Death
	Physician /Medical	Ш	disease or condition a.  Due to (or as a conseque)	nce of):			
	Examiner	_	Sequentially list conditions, If any leading to furned at the property of the conditions of the condit	neart disease			
	tuted d ansit	Examiner	If any leading it, mediation cause. Enter Underlying Cause (Disease or injury that initiated events c.	according Lierabettes			
Ö,	cate be executed ohysician and the burial-transit		resulting in death) Last Due to (or as a consequence of the consequenc	7000000			
68760	The law requires that the death certificate be executed tee has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dical	d				
Box	eath certific attending p for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant			23d. Date of delivery	
0	ne deal the att hed for	sicie	in the past 12 months?  1 □ Yes			Month Day	Year
<u>.                                    </u>	w requires that the dispersion signed by the should be detached	y Ph	Part II. Other significant conditions contributing to death but not resulting	ng in the underlying cause given in Part I.	23e. Did tobacco	use contribute to the ca	ause of death?
ords	equires en sig	ed by	diabates		1 ☐ Yes	2 ☐ No 3 ☐ Probably	4 Enknown
ပ္တ မ	e law r has be le 2 sh	Completed	diabates heart d	Tlade	24a. Was an autopsy		findings available etion of cause of
Vital Records,	sician: The I certificate harector, page	o Co	25. Was case referred to medical		performed?	death? 1 ☐ Yes 2 ☑	<del>R</del> <sub>0</sub>
ot V	hysicia his cer i direct	Ω	examiner?	26. Place of Death (Cartering Place)  26. Place of Death (Cartering Place)  3 DOA Other: 4 Nursing Home		6 ☐Other (Specify)	
0 0	Jing Pl	Certification: To	1 Natural 5 Pending (Month, Day, Year)	8b. Time of Injury at Work? 28c. Injury at Work?	d. Describe how inju		
DIVISION	Attend rr death ector: by the	ificat	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At home bullding, etc. (Specify)	M 1 ☐ Yes 2 ☐ No e, farm, street, factory, office 28f	Location (Street a	and Number or Rural Ro	ute Number.
בֿ	ital or ars afte rat Dir lled in	Cert	4 El Torricide building, etc. (Specify)		City or Town, Sta	,	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director;	edical	29a. Certifier (Check only one) (Check only one) (Check only one)	n and/or investigation, in my opinion, death occurred	at the time, date ar	(s) and manner as stated nd place, and due to the	i. cause(s)
	Vithin vithin comp	Me	29b. Signature and title of certifier	29c, License number	29d. D	Pate signed (Month, Day,	Year)
			/ E/oil, MD	766855		1412/08	
	1		30. Name and address of person who completed cause of death (Item 2:	29c. License number  DESS 5  3a) (Type, Print)  Co Bow St, Ellidan,  e. Aparlal	U15		
	Stat		31. Date filed (Month, Day, Year)  32. Registrar's Signatur	of South			
	Registra	ir .	JAN UD 2003 Brews B	· june			

JD

			Please	Type or Prin							.egible.	
		For State		State of Ma	aryland / [		tment of F ficate of	Health and N	lental Hy	giene		10170
		Registrar  1. Decedent's Nam	e (First, Middle, Li	ast)		Certi	ilcale of	Dealli	2. Date of De	Reg. No.	2008	3. Time of Death
Physic /Med		He1		Mitchel	1				Month Decembe	Day	Year 2008	5:45A M
Exami				ve street and number)		4	b. City, Town, o	or Location of Death			County of Death	
	7	Rockvil  5. Social Security N	le Nursin		e (In yrs. last bir	rthday)	Rockvi f Under 1 Year		8. Date of Bir	th	iontgome	ery uplace (State or Foreign
Funeral Director		217-32-1.		1□ M 2 <b>X</b> F	00	Yrs.	Months Days	Hours Min.	(Month, Da		Cot	aryland
and w	1	Usual Residence of	f Decedent 10b. County		10c. City, Tow	n or Locat	ion					10d. Inside City Limits
Maryli Ff sho fied af	ţō	MD <sup></sup>	Montgon	ery	Roc	kvil	le					1 ☐ Yes 2 <b>▼</b> No
ith the or 28s	Director	10e. Street and Nu	mber				10f. Zip Code			10g. Citize	en of What Cou	untry?
s 23a	eral		mingdale	Court 12, Was Decedent	Ever in II S	13 Wa		852	ecify Ves or N		SA 4. Race - Amer	ican Indian
paritimities, intal yiating A.I.A.I.3-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic and any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status  1 ☐ Never Mari 3 ☑ Widowed	ried 2 Married 4 Divorced	Armed Forces?  1  Yes 2 1  If Yes, Give  Year or Dates:			es, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)		Black, White	
2 hou	ted	A	15. Decedent's E	ducation	16a.		it's Usual Occup	pation during most of work	ina	16b. Kind	d of Business/I	ndustry
ithin 7	Completed	Elementary/Seco			College (1-4or 5+)  Komemaker			arry		Home		
filed w Hygie other t		17. Father's Name	(First, Middle, Las	t)				18. Mother's Nam	e (First, Middle	, Maiden S		
Jan Juld be Jental Aental rked o	To Be	Howard ?	Thomas Si	mmons				Stella l	Lewis			
2 short and his ma	ľ		ame/Relationship	, ,,		_		and Number or Rui		-		ip Code)
1 and 1 and Health em 27		20a. Method of Dis		.iitaw			on (Name of tory or other pla	Le Ct. Ro	Date		20852 ation - City or 3	Fown, State
Definition  Department of mportant: If it in injury or once.			☐Cremation 3 [ 5 ☐ Other (Speci	Removal from State	1				31/2008	Por	t Tobac	co, Maryland
ermit. epartm porta ny inju		21. Signature of Fr	uneral Service Lice	ensee / /	M00945	22. 🛚	REHART	ECHODS FI	UNERAL :	HOME,	P.A.	co ilai yiana
		170L	the disease or on	enlications that source	the death. Do			Mary's A			,MD 20	0646 Approximate
Physician	ı	shock, or hea immediate Cause disease or condition resulting in death)	(Final on	nplications that caused y one cause on each lin a.	Septi	cemia		ng, such as caldiac	or respiratory a	irrest,		Interval Between Onset and Death
/Medical Examiner	ı			Due to (or as	a consequence Pneum							
, d	iner	Sequentially list co if any, leading to in cause Enter Under Cause (Disease or	nditions, nmediate erlying	Due to (or as	a consequence	100000	_					
executed n and ial-transit	Examiner	Cause (Disease or that initiated event resulting in death)	S	cDue to (or as	Advan a consequence		)ementia	1	-			
e be ex			•	d	,							
rtificate ng phys	Medi	IF FEMALE:										
w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician/Medical	23b. Was deceder in the past 12 1 Yes 25	2 months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death		ctopic pregnanc other (specify) _	y		23	3d. Date of deli	very Day Year
hat the d by th	Phys	9 ☐ Unknown		contributing to death b	ut not resulting i	in the unde	ertvina cause aiv	ven in Part I	23e Did	tobacco us	e contribute to	the cause of death?
w requires to been signed should be considered.	ted by											bably 4 <b>™</b> Unknown
ding Physician: The law India Physician: The law India Physician The law India Physician India	Completed									psy ormed?	prior to c death?	topsy findings available ompletion of cause of
VICAL iclan: 'entifica ector, p	Be C	25. Was case refe examiner?	rred to medical					26. Place of Deat	1  Yes th (Check only	2 No   one)	T Tes	2   NO
Physia rthis c	2	1 ☐ Yes 2 2 27. Manner of Dea		Hospital: 1 ☐ Inpatie		utpatient Time of	3 DOY	ner: 4 Nursing Ho	ome 5 ☐ Res 28d. Describe			eify)
th. : After	tion	1 Natural 2 Accident	5 ☐ Pending investigation	(Month, Da	y Year)	Injury	28c. Inju Wor M 1 🗆	rk? ]Yes 2 □No	zod. Describe	now injury	occurred	
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicia completely filled in by the funeral director, page 2 should be detached for use as the bur	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined		ury - At home, fa c. (Specify)	arm, street	t, factory, office		28f. Location ( City or To	Street and wn, State)	Number or Ru	ral Route Number,
e Hospita 24 hours e Funera letely fille	Medical C	29a. Certifier (Check only one)	1 ← Certifying P 2  Medical Exa	hysician: To the best miner: On the basis o and manner st	f examination ar	e, death o	ccurred at the ti	ime, date and place, opinion, death occu	, and due to the rred at the time	cause(s) a , date and p	and manner as place, and due	stated. to the cause(s)
<b>To th</b> within <b>To th</b> соттр	Me	29b. Signature and	title of certifier				29c. Licens	se number		29d. Date	signed (Month	n, Day, Year)
			women			/mm		47330		Dec	ember	27,2008
BB10				D. 50 W. 1	Edmonsto			kville,MD	20852	<u>.                                    </u>		
Si Regis	ate trar	31. Date filed (Moi	DEC 3 1	32. Registr	ar's Signature	A	24					

08-09786 Marck O. Mulligan, Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Marck O. Mulligan,	1-	For State	of Maryland / De	epartment of Certificate of	Health a Death	and Me	ental Hy		g. No. 20	0 (	3 4347
Physician/	1.	gistrar Decedent's Name (First, Middle,La	st)					<ol><li>Date of Deat Month</li></ol>		1	Time of Death 1047 hrs
Medical Examine		Marck 0. M	ulligan,Jr.		0'h T	and another	as of Dooth	Month December	28, 2008 4c. County of D		1047 1113
4	48	a. Facility Name (if not institution, gi Southern Maryland Hospi		ľ	b. City, Town Clinton	, or Locali	on or Death		Prince Geo		
	_			rrs. last birthday)	If Under 1	Year If U	Inder 24Hrs.	8. Date of Bir	th (MM/DD/YYYY) 9	. Birthpl	ace (State or Foreign
Funeral Director		Total Carlotte	X <sub>M</sub> <sub>2</sub> <sub>F</sub> 49	Yrs	Months I		ours Min.			Counti	yland
		0731 sual Residence of Decedent									
any	_	0a. State 10b. County	10c.	City, Town or Locati	on						Od. Inside City Limits
Maryland 28a-f show d at once		MD P.G.		Clinton							Yes 2 XX No
ith the Maryland 23a or 28a-f sho notified at once	1	0e. Street and Number 9307 Foxcroft	Ave		10f. Zip Coo	e 2073	35		<sub>Og. Citizen of What</sub> United St		
ms 23a of be notified be notified.		1. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13. Wa	s Decedent of es, specify Cu	f Hispanic Jban, Mexi	Origin? ( Spi	ecify Yes or No Rican, etc.)	- 14. Race - A White, e		Indian, Black,
ter death with ", or items 23 er must be no		Never Married 2XX Marrie  Widowed 4 Divorce	1 Yes 2 XX N	No 1	Yes 2 X	No spe	cify:		Specify:	Whi	te ·
ours aft		15. Decedent's Education (Specify	only highest grade complete	ed) 16a. Deceder	t's Usual Occ	upation (G	Give kind of w	rork done, ed)	16b. Kind of Busin	ess/Ind	ustry
5-0036 ed within 72 hour lygiene. other than "natu the Medical Exan		Elementary/Secondary (0-12)	College (1-4 or 5+)						Compu	+	
within rene.		12	1	Comp	uter S	pecia 18 Mo	ILIST	(First, Middle,	Compu Maiden Surname)	ter	
Baltimore, MD 21215-0036  permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once To-Re Commoleted by Funeral Director		7. Father's Name (First, Middle, Las Marck Owen M	ulligan, Sr.				Maria	anna Ka	uders	<u> </u>	Code)
221 hould hould and Meris man	1	9a. Informant's Name/Relationship Carol Mulligan						Rural Route Nui Linton,	mber, City or Town, MD 2073		ip Code)
ME alth are sen 27	1	Oa. Method of Disposition		20b. Place of Dispos				Date	20c. Location - C		iwn, State
Ore,	ľ	1 Burial 2 XX Cremation		crematory or of	her place)			)	Clinton,	MT	
timent transitions of the transition of the transitions of the transitions of the transitions of the transition	-	4 Donation 5 Other Speci 21. Signature of Fundal Service Lice	20200	Lee Crem					al Home,I		5633 Old
Bal Bermi Depar Impo injur	ľ	1. Signature of All Tay Service Lice	MO1464						inton, MD		0735
Physician	1/2	23a. Part I. Enter the disease, or cor	nplications that caused the c	death. Do not enter	the mode of d	ying, such	as cardiac o	r respiratory ar	rest, shock, or heart		Approximate Interval Between Onset and
/ Medical	1	failure. List only one cause on mmediate Cause (Final disease	<sub>a.</sub> Cardiac Tamponad	e			***				Death
caminer	- 1	or condition resulting in death)	Due to (or as a consequer	nce of):							
	.	Sequentially list conditions, if any, leading to immediate	b. Aortic Dissection  Due to (or as a consequent	nce of):							
		cause. Enter Underlying Cause (Disease or injury that initiated	c							$\rightarrow$	
ed nisit	ָרְאָמ <u>ַ</u>	events resulting in death) Last	Due to (or as a consequent								
e be executed sysician and burial - transit	<u> </u>	UNPENDED	x AMENDED 5 per	r fh g887	1-22	-09 v	/t				
60, ate be hysici e buni		F FEMALE:	23c. If yes, outcome of	f pregnancy					23d. Date of de		
Box 6876C e death certificate the attending phys ed for use as the b	2	3b. Was decedent pregnant in the past 12 months?	1 Live birth  1 Pregnant at time		etal death		ctopic pregna	ancy	Month	Da	y Year
OX (eath of attent for us	Fillysici	1 Yes 2 No 9 Unkno		ordeath 5 C	ther (Specify	)					
ires that the death ires that the death signed by the atte		Part II. Other significant condition	s contributing to death but	t not resulting in the	underlying ca	use given	in Part I.		tobacco use contrib		
P.O. es that the iigned by be detac								1Y			bly 4 V Unknown
cords, law requir has been s	E								ppsy pri	ior to co	ppsy findings available mpletion of cause of
Reco The law cate has	Completed							perf 1 ✓ Yes		ath? ✔ Yes	2 No
ital Recition: The scentificate	۲ ا	25. Was case referred to medical			26		eath (Check	only one)			
Vita hysicia this ce		examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient	2 ER/Outpatie				ng Home 5	Residence 6	Other:	
Division of Vital Records, tal or Attending Physician: The law require its after death. I'll Director: After this certificate has been similar in by the funeral director, page 2 should be in by the funeral director, page 2		27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of	′ ′	c. Injury at		28d. Describe	e how injury occurred	3	
ion Itendi leath.	띪	1 Natural 5 Pending 2 Accident Investig	ation					20f Leasting	(Street and Number	r or Pur	al Route Number, City
ivisior or Attence after death Director:	Certification:	3 Suicide 6 Could r		- At home, farm, str	eet, factory, o	ffice buildi	ng, etc.	or Town,		Oi Nois	if Mode Namber, Oily
Divi Hospital or 24 hours afte Funeral Dir stely filled in		4 Homicide	ned (Specify) sician: To the best of my kn	evilodes, double occ	urred at the ti	me date a	nd place an	d due to the ca	use(s) and manner a	as state	d.
Division of Vital Records, P.O. Box within 24 hours after death within 24 hours after death. To all the Funeral Director: After this certificate has been signed by the atternormal Director: After this certificate has been signed by the atternormal Director: After this certificate has been signed by the uneral director, page 2 should be detached for a completely filled in by the funeral director, page 2 should be detached for a completely filled in by the funeral director, page 2 should be detached for a completely filled in by the funeral director, page 2 should be detached for a completely filled in by the funeral director.	σ	(Check only 1 Certifying Physone) 2 ✓ Medical Exami	ner:On the basis of examina	ation and/or investig	ation, in my o	pinion, dea	ath occurred	at the time, dat	e and place, and du	e to the	cause(s)
To the within 2 To the complete	g -	29b. Signature and title of certifier	and manner stated.			icense nu			29d. Date signe		
		auo De	ı.			O.C.M.E	Ξ.		December 2	29, 20	38
	ŀ	30. Name and address of person w	no completed cause of death	h (Item 23a)							
BB6 1		Ana Rubio MD. Assis	tant Medical Examine	er 111 Penn	Street, Ba	ltimore,	MD 2120	)1			
Sta		31. Date filed (Month: Pay, Year)	2008 32 Registrar's S	Signature	whit						
Registr	r: 1 i	The state of the s	1	-	- CHI CALL						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 12/28 7 2008 Year Bernard Webster Moulton 9:30am м /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Arbor at Baywoods Annapolis Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days 1**X**M 2□ F Months Hours 972974926 068-16-4776 88 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 28a-f show 10d Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the "fedical Examinar must be notified at MD Anne Arundel Annapolis Director 1 ☐ Yes XX No with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7101 Bayfront DR. 21403 USA permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural"; or items any injury or other traumatic manages. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1XXYes 2 No Vietnam If Yes, Give Year or Dates: 1 Never Married 200 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXXVo Specify White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Officer US Navy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Webster Collins Moulton Hazel Marie Cohn 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ann M. Elliott Daughter Ewing, NJ 08628-2005 11 Duffield Dr. 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Atlantic Crematory 12/30/2008 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fune al Service Licensee 22. Name and Address of Facility Hardesty Funeral Rome, P.A. 12 Ridgely Ave. Annapolis, MD 21041 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Mesothelloma Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of the attending physician and hed for use as the burial-transit the death certificate be executed Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month 4 Pregnant at time of death 5 Other (specify) □Yes 2□No 9 Unknown signed by t The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 Nes 2 No 3 Probably 4 Unknown Completed 24a, Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has be 2 s page certificate 1 □ Yes 2 or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2X No Other: 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation To the Hospital or Auton.

within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fur 1 Natural 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

and manner stated. (Check only one) ause of Jeath (Item 23a) (Type, Print) Pefense Hry, Crofton, MDR1114 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year DORIS PHILLIPS DECEMBER 26 2008 8:32A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK MONTGOMERY 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 1 F Months Days Hours Min Director 261-54-9374 JUNE 5 1938 FLORDIA Usual Residence of Decedent 10a. State 10c. City, Town or Location show 10d. Inside City Limits ?7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, The Madical Evanting must be motified at MDPRINCE GEORGE'S CAPITOL HEIGHTS Director 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5801 FOLGATE COURT 20743 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify þ Specify: BLACK 3 ☐ Widowed 4 🎇 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th OFFICE MANAGEMENT PRIVATE permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If item 27 is marked other I any injury or other traumatic event, III 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be RAYFORD SERMON EDITH SERMON 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROD SERMON/SON 5801 FOLGATE COURT CAPITOL HEIGHTS, MARYLAND 20743 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) HARMONY CEMETERY 1/3/2009 LANDOVER, MARYLAND 22. Name and Address of Facility rvice License J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** eroscleronic disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): law requires that the death certificate be executed g physician and stranger the burial-tranger Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 5 Other (specify) signed I be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 1 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe 1 □ Yes 1 ☐ Yes 2E No 2 4NO 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | N 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner eath 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Julitural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. investigation 1 □ Yes 2 □ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MO 12-27-08 D0066/00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THIM I WA

Registrar
DHMH 17 Rev 1/2001

State

BLVD

32. Registrar's Signature

University

31. Date filed (Month, Day, Year)

DEC 3 1 2008

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.2 () () 8 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Month HAZEL M. PILCHARD 12 31-3008 AM /Medical 3:04 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Scalisbury
If Under 1 Year If Under 24 Hrs. Hospice at the Lake wiconico Coastal Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Months Days Hours Min 1 □ M 2 🛛 F Director 220-12-1592 85 11/6/1923 Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho Injury or other traumatic event, the Maxical Examinar must be notthed at Director 1 ☐ Yes 2 XNo MDWorcester Pocomoke 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4127 Stockton Road 21851 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates: 2 Specify: white 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the M. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Samuel Marshall Addie Marshall 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Hasty (daughter) 4146 Stockton Rd., Pocomoke, MD 21851 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State N Burial 2 ☐ Cremation 3 ☐ Removal from State First Baptist Cemetery 1/3/2009 Pocomoke City, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Holloway Funeral Home, Professional Association 103 Linden Ave., Pocomoke City, MD 21851 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ongestive /Medical Due to (or as consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed slaund attending physician and for use as the burial-trar Due to (or as a consequence of): P.O. Box 68760 Physician/Medical Orona IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year signed by the a 1 ☐ Yes 2 ☐ No 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed s certificate has b irector, page 2 si 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 1 ☐ Yes 2 ☐ No 1 □ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1050 (C 2) No 1 ☐ Yes Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only 29b/Signaty 29c. License number 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of ath (Item 23a) (Type, Print) Registrar's Signature State Jarke Registrar

		1 - For State Registrar	State of Maryla		artment of He rtificate of D			ne No D D D	1.31.83
Physic /Med		1. Decedent's Name (First, Middle, Last  Marie Alice Rus	,				2. Date of Death Month	Day 9 2 Ye ar	3. Time of Death
Exami		4a. Facility Name (If not institution, give	,		4b. City, Town, or L			4c. County of De	ath
<i>F</i>		Washington County 5. Social Security Number 6. Se		rs. last birthday)		rstown If Under 24 Hrs.	9 Data of Birth	Washi	
Funeral Director		212-14-7876	_ м 2Д <b>х</b> F 86	Yrs.		Hours Min.	8. Date of Birth (Month, Day, Ye lay 16,19	22 9. Bi	rthplace (State or Foreign Country) aryland
and		Usual Residence of Decedent  10a, State 10b, County	10c.	City, Town or Lo	cation				10d. Inside City Limits
Maryl a-f sho	tor	Md. Washir			ni thsburg				1 ☐ Yes 2 ☐ No
ith the	Director	10e. Street and Number			10f. Zip Code		10g.	Citizen of What C	ountry?
leath v	Funeral	22534 Jefferson H	31Va . 12. Was Decedent Ever in	115 13		783	ifu Va a au N	U.S	
and 21215-0036 be filed within 72 hours after death with the Maryland ntal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Modical Exprint mist be recitived at	þ	1 ☐ Never Married 2 ☐ Married 3 😿 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of Hisp If Yes, specify Cuban, 1 □ Yes 2 ☑ No	Mexican, Puerto R	ican, etc.)	14. Race - Am Black, Whi	
Maryland 21215-0036 d 2 should be filed within 72 hours aft th and Mental Hygiene. 77 is marked other than "natural", or traumatic event, the Medical Exertit	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed) College (1-4or 5+)	(Give	dent's Usual Occupati kind of work done dur DO NOT use retired)	ring most of working	16b	. Kind of Business	,
d 21 filed wi Hygier other th		17. Father's Name (First, Middle, Last)		Of	fice Clerk			Aircraft	<u> </u>
Iryland 2 hould be filed and Mental Hygi marked other matic event, II	To Be	David H. Horn			11	8. Mother's Name (	First, Middle, Maid $E$ . Weave		
Taryla 2 should and Mer is marke aumatic	-	19a. Informant's Name/Relationship (Ty	pe. Print)	19b. Mailir	ng Address (Street and				Zip Code)
		V. Louise Varner		P.O.	Box 1089 S				•
O 82 = 5		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F		o. Place of Dispo cemetery, cren	sition (Name of natory or other place) g Cremator	Dec.	31,	Location - City or	
Baltim permit. Pag Department Important; any Injury once.		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service License			. Name and Address	2000		nithsburg	
any med med one		Joffen LEC 1		I	L. Davis F	•	ome Smits	Bradburg,Md.	ry Ave. 21783
Physician /Medical		23 Firt / Filer th of sease, or complish or heart failure. List only or in mediate Cause (Final disease or condition resulting in death)	cations that caused the de le cause on each line.  Due to (or as a conso				respiratory arrest,		Approximate Interval Between Onset and Death
Examiner			Due to (or as a conse	equence or):	act In	nct			L
ed sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	equence of):					
567 6U, ficate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a conse	equence of):					
8 / 6U sate be only sicial	dical		·						
x bx	/Med	IF FEMALE:	20 If you cutooms of you						
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time o 9 ☐ Unknown	etal déath 3 🗆	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
S, T es that igned!	by P	Part II. Other significant conditions con	tributing to death but not re	esulting in the un	derlying cause given i	in Part I.	23e. Did tobacco	o use contribute to	the cause of death?
cords v requires been sign should be	eted	Carciana a	ian shu	u br	ni ona	india	1 □ Yes	2 □ No 3 □ Pi	robably 4 Unknown
he law he has t ge 2 s	Completed	Wohntenan .	hoperlynd	enni			24a. Was an autopsy	prior to	utopsy findings available completion of cause of
VILAI iclan: Ti certificate ector, pa	0	25. Was case referred to medical	Sullen			Disc. (B. 1) (	performed?	death? 1 ☐ Yes	2 □ No
nysicl	_ œ	examiner?	ospital:	☐ ER/Outpatient	Cilia	<ol> <li>Place of Death (€</li> <li>A □ Nursing Home</li> </ol>		6 □Other (Spo	oih A
nding Pl th. : After the	ü	27. Manner of Death  1  Pending	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?		d. Describe how inj		city)
Attender death ector:	ficat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At I	home form etre		2 □No	Lanction (G)	_,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
spital or / ours after leral Dire	Certification: To	4 ☐ Homicide determined	building, etc. (Spec	cify)			City or Town, Sta	ite)	ıral Route Number,
To the Hosp within 24 hou To the Fune completely fi	Medical	29a. Certifier (Check only one)  1	ician: To the best of my kr er: On the basis of examir and manner stated.	nowledge, death nation and/or inv	occurred at the time, estigation, in my opini	date and place, and ion, death occurred	d due to the cause at the time, date a	(s) and manner as and place, and due	s stated. to the cause(s)
To t With To t	Σ	29b. Signature and title of certifier			29c. License nu			Date signed (Month	
		- tale			D 12	-0 (9	C O	EC 30	2003
5H·10		30. Name and address of person who cor	npleted cause of death (Ite	em 23a) (Type, P		17 21A	CERSTO	wa m	021743
Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature	Contract 6				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Dec 28, 1. Decedent's Name (First, Middle, Last) **Physician** William J. Richards 2008 5:45 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Galesville

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

Nov 28, 1937 914 Galesville Road Anne Arundel 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 71 Maryland 218 34 7391 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Modical Experiment must be realfied at 10d. Inside City Limits Director Marvland Anne Arundel Galesville 1 ☐ Yes 2 XXVo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 914 Galesville Road 20765 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. Armed Forces?

1 Yes 2770 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 □Yes 2√TNo 2 Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Flooring Construction permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If item 27 is marked other any injury or other. Be ( 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William G. Richards Virginia Hardesty ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan Richards (WIFE) 914 Galesville Road, Galesville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Marial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cemetery 1/03/2009 | Clinton, Maryland 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d 700153 Alexandria Ferry Road, Clinton, MD 23a. P fr. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death UNG mediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No autopsy 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \sum Nursing Home Certification: To 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Residence 6 Other (Specify) After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending 2 Accident investigation 1 🗆 Yes 2 No 24 hours after death Funeral Director: 3 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier

within 2

Division of Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

BBID State Registrar

(Check only one)

31. Date filed (Month,

29b. Signature and title of certifier

30. Name and address of person who completed duse of death (Item 23a) (Type, Print)

32. Registrar's Signature

516364 12/29/08 STEATE Rd. 3 00 Annapolis M21401

			1 - State of State of Registrar		artment of Health ar rtificate of Death	, ,	ene I No. 2 A A Q	1, 21, 05
ı	Physici /Medic		1. Decedent's Name (First, Middle, Last) Tom Peter Ribis			2. Date of Death Month 12/2	287/2008 Year	3. Time of Death 1:00am м
	Examir		4a. Facility Name (If not institution, give street and num 5 Eastern Ave.		4b. City, Town, or Location of Annapolis		4c. County of Death Anne Aru	
ı	Funeral Director		242-72-8562 152kM 2□ F	7. Age ( <i>In yr</i> s. last birthday) 62 Yrs.	If Under 1 Year	Min. 8. Date of Birth Min. 5/19/19	Year) 9. Birthp	lace (State or Foreign htry) NC
	Maryland a-f show	tor	Usual Residence of Decedent  10a. State 10b. County  MD Anne Arundel	10c. City, Town or Lo			1	0d. Inside City Limits 1 ☐ Yes 🛣 No
	with the	I Dire	10e. Street and Number 5 Eastern Ave.	-	10f. Zip Code 21403	100	g. Citizen of What Coun	itry?
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Evaring must be notified at once.	by Funeral Director		ces? 2 <b>/T/N</b> 0 e	Was Decedent of Hispanic Origin	n? (Specify Yes or No- Puerto Rican, etc.)	14. Race - Americ Black, White, & Specify: Whi	etc.
21215-0036	within 72 ho ene. than "natur he Medical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-5+	4or 5+) (Give	dent's Usual Occupation kind of work done during most o DO NOT use retired)  Developer	f working	Software	dustry
yland 2	ould be filed Mental Hygi arked other atic event, n	To Be Co	17. Father's Name (First, Middle, Last) Peter Ribis		18. Mother's	Name (First, Middle, Ma	iden Surname)	
Mar	and 2 sho alth and 27 is m er traum	1	19a. Informant's Name/Relationship (Type. Print)  Debbie Ribis Spouse	T T	ng Address <i>(Street and Number</i> tern Ave. Annap			Code)
Baltimore, Maryland	Pages 1 a tment of He tant: If item jury or othe		20a. Method of Disposition 1 ☐ Burial 2分℃remation 3 ☐ Removal from \$ 4 ☐ Donation 5 ☐ Other (Specify)	Atlantic	-	2/30/2008 G	c. Location - City or To len Burnie	, MD
Ball	Departit Depart Import any in		21. Signature of Funeral Service Ocensee		2. Name and Address of Facility 2 Ridgely Ave.			, P.A.
	Physician /Medical Examiner	100	23a. Part 1. Enter the disease, or complications that constant shock, or heart failure. List only one cause on earn tended to the shock of the shock	tused the death. Do not ent ich line. Dor as a consequence of):	er the mode of dying, such as ca	No. 1 EVENTS		Approximate Interval Between Onset and Death
58760,	icate be executed physician and the burial-transit	al Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	or as a consequence of):				
O. Box 68	sath certif attending for use as	Physician/Medical	in the past 12 months?	ant at time of death 5	Ectopic pregnancy Other (specify)		23d. Date of delive Month	ery Day Year
rds, P.	w requires that the de been signed by the should be detached	ð	Part II. Other significant conditions contributing to de	ath but not resulting in the u	nderlying cause given in Part I.		cco use contribute to th	
tal Records,	Physician: The law re this certificate has ber al director, page 2 sho	e Completed	25. Was case referred to medical	,	OS Place	24a. Was an autopsy performe 1 □ Yes 2)	prior to cor death?	psy findings available inpletion of cause of 2
of V	Physicia this cer al direct	To Be	examiner? 1 Yes 15 No Hospital: 1 1 1	npatient 2 ER/Outpatier	nt 3 □ DOA Other: 4 □ Nurs	ing Home 5 Residence		y)
Division of Vital	r Attending Ph er death. rector: After th by the funeral.	Certification: To	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place	of Injury 1, Day, Year)  28b. Time of Injury 27  28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury	Work?  M 1 □ Yes 2 □ No		et and Number or Rura	l Route Number,
	To the Hospital or Attend within 24 hours after death To the Funeral Director: / completely filled in by the f	Medical Cer	29a. Certifier  (Check only)  2 Medical Examiner: On the ba	best of my knowledge, deatl sis of examination and/or in	n occurred at the time, date and vestigation, in my opinion, death	place, and due to the cau	use(s) and manner as s	tated.
	To the within 2	Med	29b. Signature and title of certifier	er stated.	29c. License number	290	Date signed (Month, I	Day, Year)
1	0		30. Name and address of person who completed cause	of treath (Item 28a) Type,	Print) RP	300 AM	Males	mil
	Sta	te	31. Date filed (Month Day, Year) 2000 32. As	gistrar's Signatur				3

Registrar
DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Day Month Beverly Sisler 2:00 pM Ann /Medical December 22, 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Suburban Hospital Bethesda Montgomery Co. | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Nin. | February 18, 1945 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🔀 F Yrs. Director 002-32-4908 63 New Hampshire Usual Residence of Decedent death with the Maryland 10a State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director VA 1 ☐ Yes 2 ☐ No Falls Church Fairfax Co. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Gountry? 609 Knollwood Drive 22046 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify. þ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12 Beautician Owner "Bev's Place" permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked ofth any liquy or other traumatic event any liquy or other traumatic event ange. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Walter Drapeau ဂ Jessie Patriquin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Henry E. Sisler 609 Knollwood Dr., Falls Church, VA 22046 20b. Place of Disposition (Name of cemetery, crematory or other place) National Memorial 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ➡ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Park 12-30-08 Falls Church, VA 21. Signal 22. Name and Address of Facility 1102 W. Broad St. Murphy Falls Church F.H. Falls Church, VA 22046 23a. Dert 1. Enter the disease of comprications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Sepsis /Medical Due to (or as a consequence of): Examiner End Stage Renal Disease 48 hrs. Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Multiple Myeloma Hospital or Attending Physician: The law requires that the death certificate be execut 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and 3 months Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No cate has t 24a. Was an Division of Vital 2 🔯 No 1 □Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 X Natural 2 Accident 1 ☐ Yes 2 No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide e Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only To the I within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MP D0066990 30. Name and address of person no completed cause of death (Item 23a) (Type, Print) 6420 Rockledge Dr., Bethesda, MD 20817 Vinni Juneja 31. Date filed (Month, Day, Year) 32. Registrar's Sign State DEC 3 1 2008 Registrar

			For State	State of Ma	aryland		rtment of		d Mental H		ne 10.2008	43487
			Registrar  1. Decedent's Name (First, Middle, La.	st)			inicate of	Death	2. Date of D			
	Physici /Medic		Tracie Le	igh Simmer	s				Dec 20	Г.	008 Year	6:28 A M
	Examin	er	4a. Facility Name (If not institution, give	· ·	. 1		4b. City, Town,		eath		c. County of Death	
-			Southern Mary  5. Social Security Number 6. S			ast birthday)	If Under 1 Year	nton   If Under 24	Hrs. 8. Date of B		Prince Ge	orge's
	Funeral Director			ПМОПЕ	0	Yrs.	Months Days		Min. (Month, E	av, Yea	r) Coul	ington DC
	pu »		Usual Residence of Decedent  10a. State 10b. County		100 City	, Town or Lo	nation				14	0d. Inside City Limits
	Maryla a-f shov	ctor	10a. State 10b. County  Maryland Prince G	eorge's		linton	Jation					1 □ Yes 2 □ No
	or 28	Director	10e. Street and Number				10f. Zip Code			_	Citizen of What Cour	•
	s 23a	eral	7520 Surratts		Corner im 11 C	2 42.1		735	2 (Cit-)/ or N		ted State	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Eva at the health once.	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4√ Divorced	12. Was Decedent I Armed Forces? 1 □ Yes 2 X X If Yes, Give Year or Dates:			vas Decedent of f Yes, specify Cul □ Yes 2 □		? (Specify Yes or N uerto Rican, etc.)	0-	14. Race - Americ Black, White, Specify: Wh	
215-0036	2 hou	ted	15. Decedent's Ed	lucation		16a. Dece	lent's Usual Occu	pation	working	16b.	Kind of Business/In	dustry
2121	I within 7 jiene. r than "r	Completed	(Specify only highest gra	College (1-4or 5	+)	Homem	kind of work done DO NOT use retire aker	ed)	Working	0	wn Home	
Maryland 2	the filed antal Hyg ed others event,	Be	17. Father's Name (First, Middle, Last) William Ed		h , S	Sr.			Name (First, Middle ion Virgi		,	
ary.	should and Mer s marke umatic	은	19a. Informant's Name/Relationship (	9a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 2								
	and 2:		Kelly Antosh (Sis	ter)		1830	Harvest	Grove L	ane. Pri	ice	Frederick	. MD 20678
ore,	es 1 a of He of He rothe		20a. Method of Disposition		20b. Pl		sition (Name of natory or other pla		Date		Location - City or To	
Ē	Pages ment of I ant: If ite		1 ☐ Burial 2 <b>XX</b> Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	y)	Lee		atory De		800		Clinton,	
Baltimore,	permit. Departi Imports any Inji		22. Name and Address of Facility Lee Funeral Home, Inc 6633 Alexandria Ferry ROAD, Clinton, MD 20735 33. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximation									
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each lin	the death	. Do not ent	er the mode of dy	ing, such as car	rdiac or respiratory	arrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. 1 m	um	onia						Onset and Death
1	/Medical Examiner		resulting in death)	Due to (or as	a consequ	ience of):						
		- Fe	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequ	ience of):						
	cuted nd ansit	Examiner	Sequentially last orindrois, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  C									
ó,	icate be executed physician and the burial-transit		resulting in death) Last	Due to (or as	a consequ	ience of):						
8760,	cate b ohysic the bi	dical		d								
O. Box 6	ath certif attending for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ØNo 9 □ Unknown	23c. If yes, outcome 1  Live birth 4  Pregnant at 9  Unknown	2 🗌 Fetal	death 3	Ectopic pregnan	су			23d. Date of delive Month	ery Day Year
ď.	res that the de signed by the a be detached t	by Ph	Part II. Other significant conditions	ontributing to death bu	ıt not resu	ılting in the ur	nderlying cause gi	ven in Part I.	23e. Did	tobacco	o use contribute to t	he cause of death?
ord	v require been sig should b	ed k							1	Yes	2 No 3 Prot	pably 4 TUnknown
Records,	siclan: The law r certificate has be irector, page 2 sh	Completed				-			_ per	opsy formed?	prior to co death?	psy findings available mpletion of cause of
Vital	siclan: The certificate h rector, page	Be C	25. Was case referred to medical		_			26. Place of	1 ☐ Yes Death (Check only	2 D	Vo 1 □ Yes	2 🗖 No
Ž V	Physic this ce al direc		examiner? 1 □ Yes 2 ☑No	Hospital: 🎁 Inpatie	nt 2 🗆 I	ER/Outpatier	t 3 □ DOA Ot	her: 4 🗌 Nursir	ng Home 5 ☐ Res	sidence	6 ☐ Other (Special	fy)
	Jing J. After fune	tion:	27. Manner of Death  1. ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inju (Month, Day	ry v, Year)	28b. Time of Injury	28c. Inju Wo M 1 [	ıryat rk? ∐Yes 2 ∐No	28d. Describe	how inj	jury occurred	
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injubulding, etc	iry - At hoi :. (Specify	me, farm, str	eet, factory, office		28f. Location City or To	(Street wn, Sta	and Number or Rura ate)	al Route Number,
	To the Hospita within 24 hours To the Funeral completely filled	Medical C	29a. Certifier Certifying Pr (Check only one) Certifying Pr 2 Medical Exar	nysician: To the best on the basis of and manner sta	of my know examinat	wiedge, deatl tion and/or in	occurred at the vestigation, in my	time, date and p opinion, death	place, and due to the occurred at the time	e cause e, date a	e(s) and manner as s and place, and due to	stated. the cause(s)
	To the within To the COMP	Me	29b. Signature and title of certifier				29c. Licen	se number		29d. [	Date signed (Month,	Day, Year)
			m Sin				DES	365		15	-20-6	
R	32		30. Name and address of person who	completed cause of d	eath (Item	23a) (Type,	Print)	4101 -	foot CAT	Lyto	pate signed (Month,	20166
4	Sta	te	31. Date filed (Month, Day, Year) DEC 3 1 20	3 Registra	ar's Signat	ture	1 (1)			0		
	Registr	ar	DEC 9 T SI	JUB JOHN	1 10	God						

Division of Vital Records, P.O. Box 68760,

altimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely lifled in by the funeral director, page 2 should be detached for use as the burial-transit Certification: To 29a. Certifier 1 🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 73206 Doc +4 he 27, 2008

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11701 LIVINGAM 31. Date filed (Month, Day, Year)

DEC 3

32. Registrar's Signature

lood For Washington mary me

			1 - For State Registrar	State of Mar	•		f Health a of Death	and Mental Hy	gier 2008	43489
			Decedent's Name (First, Middle, Last)					2. Date of De Month		3. Time of Death
10	Physici /Medic Examin	al	Ruth Eleanor Sto  4e. Facility Name (If not institution, give s			4b. City, Tow	m, or Location of	Decemb		
			3135 National Pike			Hancoo			Washingt	
1	Funeral Director		5. Social Security Number 6. Sex 1 □	M 2☐F 7. Age	(In yrs. last birthday) 83 <sup>Yrs.</sup>	If Under 1 You Months Da	ear If Under	Min. 8. Date of Bir (Month, Da		thplace (State or Foreign ountry)
	pur A		Usuel Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	Aaryk s sho	ō	MD Washingto	in	Hancock					1 ☐ Yes 2 No
	28a-	Director	10e. Street and Number		Hancock	10f. Zip Coo	de		10g. Citizen of What C	ountry?
	3a or	Ö	3135 National Pi	ke		21	750		USA	
	death	Funeral		2. Was Decedent Ev Armed Forces?	ver in U.S. 13.	Was Decedent	of Hispanic Ori	gin? (Specify Yes or No., Puerto Rican, etc.)		
9	or Ite		1 Never Married 2 Married	1 Yes 2 No	)	1 ☐ Yes 21√2		*	Specify:	
8	72 hours after death with the Maryland natural; or Iteme 23a or 28a-f show disal Examiner must be redified at	d by	3 X Widowed 4 □ Divorced	Year or Dates:					Whi	
15	n 72 I	Completed	15. Decedent's Educ (Specify only highest grade	completed)	(Give	dent's Usual Oo kind of work do DO NOT use re	one during most	t of working	16b. Kind of Business	vindustry
212	iene.	mo	Elementary/Secondary (0-12)	College (1-4or 5+	Clerk				Retail Sal	.es
ğ	be filed tal Hygi d other event, I	Be C	17. Father's Name (First, Middle, Last)				18. Mothe	r's Name (First, Middle	, Maiden Sumame)	
/lar	should b nd Menta marked	To	Joseph M. Divelbl	iss			Carr	cie A. Dieh	1	
Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Marylan 1 of Health and Mental Hygiene. If Item 27 is marked other than "natural", or Iteme 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Type						er, City or Town, State,	Zip Code)
	l and lealth im 27 her ti		Franklin G.Stotler 20a. Method of Disposition	/Son	14029 20b. Place of Dispo	Round	Too Ros	d Hancock,	MD 21750 20c. Location - City of	Town State
10	Pages hent of the		1 Deurial 2 Cremation 3 Re	emoval from State	cemetery, cre	matory`or other	place)			
Baltimore,			'4 ☐Donation 5 ☐ Other (Specify)  21. Significant of Funeral Service License	n A	Mt.Olivet		ddress of Facilit	-	Hancock, MD	
Ba	permit. Departr Imports eny inj		100	- CK				141 West	Main Street cock,MD 217	
	Pnysician /Medical Examiner		23a. Pert1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Seguentially list conditions.	Due to (or as a	consequence of):	ter the mode of				Approximate Interval Between Onset and Death
68760,	cate be executed physicien and the burial-transit	dical Examiner	Sequentially list conditions, tarry, Lading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		consequence of):					
.O. Box	The law requires that the death certificat tie has been signed by the attending phy agge 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	3c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetel death 3	□Ectopic pregn □ Other (specif			23d. Date of de Month	olivery Day Year
Vital Records, P.	uires that n signed b	by	Part Other significant conditions con	tributing to death but	not resulting in the u	Inderlying cause	e given in Part I		tobacco use contribute t ¥6s 2 □ No 3 □ P	robably 4 \(\sum \)Unknown
CO	s been si	ojete		Cli	sien		`	24a. Was		utopsy findings available
Re	The lav	Completed	/					auto perfo	psy ormed? death? 2 ☐ No 1 ☐ Ye	
ita		BeC	25. Was case referr the medical examiner?					of Death (Check only		
of <	Physician: rthis certific rai director.	To	1 ☐ Yes 2 € No		t 2 ER/Outpatie				idence 6 Other (Spe	ecity)
Č	10 E	on:	27. Man of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day	Year) 28b. Time o		Injury at Work?		how injury occurred	
Division	Atten or deat ector: by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injur building, etc.	ry - At home, farm, st (Specify)	M reet, factory, of	1 Yes 2	28f. Location (	Street and Number or F wn, State)	iural Route Number,
	To the Hospitel or within 24 hours afte To the Funerel Dir completely filled in	edical C	29a. Certifier 1 Certifying Phys	sician: To the best of ner: On the basis of e and manner state	examination and/or in	th occurred at the overstigation, in	he time, date an my opinion, dea	d place, and due to the th occurred at the time,	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	. /		29c. L	cense number	7	29d. Date signed (Mon	th, Day, Year)
•			Juden !	- Un	1 ms		2362	3	January (	,2009
			30. Name and address of person who co	appleted cause of de	ath (Item 23a) (Type	Print)	1. 1	1	1 16.	1
			31. Date filed (Month, Day, Year)	A Registrar	r's Signature	) Mec	suce (	empus 12	a telen	Trom Wil
	St Regist	ate rar	IAN & KONNO	Bushes	A Bon	RD.				21742

DK-

			For State Registrar	State of Ma	ırylan			nt of H i <i>te of L</i>		and Me	ental Hy		2008	43490		
			1. Decedent's Name (First, Middle, Last)  2. Date of Deat										3. Time of Death			
	Physici		Mary Elizabeth Th				I	Month Decemb	er 28	2008	2:15 P <sup>M</sup>					
1	/Medio Examir		4a. Facility Name (If not institution, give				4b. Cit	y, Town, or	Location o				County of Death	1		
	CAGIIII	ICI	Ravenwood Luthera	n Village			Нао	ersto	wn			Wa	ashingto	n		
	Funeral		5. Social Security Number 6. S		(In yrs.	last birthday)	If Und	er 1 Year_	If Under 2		B. Date of Bi	rth	9. Birth	place (State or Foreign		
	Director		219-36-3930	□M 2[ <b>]</b> F	92	Yrs.	Month	Days	Hours	Min.	(Month, D July 9			intry) /land		
			Usual Residence of Decedent								oury 2	,,,,,				
	ylan now		10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits		
	Mar-f s	tor	Maryland Washingt	on	Hag	erstow	'n							1⊠Yes 2□No		
	r 28	Director	10e. Street and Number				10f. 2	ip Code				10g. Citi	izen of What Cou	intry?		
	33a o	a D	1190 Luther Drive				21	740				U	SA			
	ms 3	Funeral	11. Marital Status	12. Was Decedent E	ver in U.	S. 13.			spanic Ori	gin? (Spec	ify Yes or No ican, etc.)		14. Race - Amer			
21215-0036	be filed within 72 hours after death with the Maryland that Hyglene.  ad other than "natural", or items 23a or 28a-f show event, It a Modical Examination in cofficial at		1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1	0		ir Yes, sp 1 ∐Yes		Specify:	, Puerto A	ican, etc.)		Black, White, Specify: Whi			
9	2 hor	Completed by	15. Decedent's Ed	ucation	- 1	16a. Dece	dent's Us	ual Occupa	ation	of		16b. Kii	nd of Business/Ir	ndustry		
215	in 7.	ple	(Specify only highest gra	de completed) College (1-4or 5-	L)	life.	KING OF W DO NOT	ork done d use retired	luring most )	or working	7					
21	filed withii Hygiene. other than ent, It o IV	5	12	4	.,	Teach	er					E	ducation			
g	othe vent,	Be C	17. Father's Name (First, Middle, Last)						18. Mothe	r's Name (	First, Middle	e, Maiden	Surname)			
ā	buld be f Mental arked of attc eve	10	Guy Stanley Tho	mas					Lilli	ian B	3ertha	Pa	lmer			
ä	AS DE E		19a. Informant's Name/Relationship (	ype. Print)		19b. Mailir	ng Addre	ss (Street a	and Numbe	er or Rural	Route Numb	per, City o	r Town, State, Zi	p Code)		
Ξ	# H H		Phyllis M. McClea	f		212 S	outh	Fork	Driv	e Had	gersto	wn. I	MD 2174	10		
ē,	s 1 and of Healt Item 2 other		20a. Method of Disposition		20b. P	Place of Dispo				Da			cation - City or T			
η.	age: ent o nt: #		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify			. View			i	. 31,	2008	Shar	enchura	Maryland		
Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 any Injury or other Once.		21. Signature of Funeral Service Liden		1914	0 <sup>22</sup>	Name :	and Addres	s of Facility	Home	P.A.	425		cocheague S		
_			MUCON			W i	llia	mspor	T, Ma	aryla	nd 21/	95				
			23a. Enter the disease, or comp shock, or heart failure. List only	lications that caused one cause on each lin	the death e.	h. Do not ent	er the mo	ode of dyin	g, such as	cardiac or	respiratory a	arrest,		Approximate Interval Between Onset and Death		
-	Physician		Immediate Cause (Final disease or condition Corporaty at they as Season							DQ		Years				
	/Medical		resulting in death)	b. Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):						. 0	ia year					
	Examiner		Cognestially list conditions							aldi						
	p +	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying							-h- (	A1.0		J			
	cute	ami	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  Due to (or as a consequence of):  N 15 +054 of Chym it						O privuent				years			
ó	an al rial-t	Ä	resulting in death) Last  Due to (or as a consequence of):													
68760,	ficate be executed physician and s the burial-transit	edical	•	d					J							
	ntifica ng ph as th	Jed	IE ECAMAL C.													
Вох	eath certific attending p for use as	N/UE	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death					3 ☐ Ectopic pregnancy					23d. Date of deliv			
<u>.</u>	deal le att	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☒ No	4 ☐ Pregnant at			Other (						Month	Day Year		
P.0	that the de ned by the detached	hys	9 ☐ Unknown 9 ☐ Unknown								T					
ď,	The law requires that the death certificate has been signed by the attending bage 2 should be detached for use as	by P	Part II. Other significant conditions of				nderlying	cause give	en in Part I.		23e. Did	tobacco u	ise contribute to	the cause of death?		
ğ	w requires t been signe should be		alla	se to	MI	IV J.					1 🗆	Yes 2	□ No 3 □ Pro	bably 4 💢 Unknown		
ပ္ပ	s bee	let									24a. Was		24b. Were auto	opsy findings available		
Re	The law cate has page 2 a	Completed										ormed?	prior to co	ompletion of cause of		
ā		ပိ	25. Was case referred to medical						26 Place	of Dooth /	1 □Yes Check only o	(	1 □ Yes	2/KJNo		
5	Physician: rthis certifici ral director, p	<u> </u>	examiner?	Hospital:	* 2 D	ER/Outpatier		Othe					6 ☐ Other (Speci			
of		- T	27. Manner of Death	28a. Date of Injur		28b. Time of		28c. Injury Work			d. Describe			ту)		
on	ding P. Afte fune	ţi	1 ☑ Natural 5 ☐ Pending	(Month, Day,	Year)	Injury	м		? ⁄es 2 □ N							
S	Attending It death. ector: After by the fune	lica	2 Accident and Investigation a							Street and	treet and Number or Rural Route Number,					
=	after after Dire	Certification:	4 Homicide determined determined building, etc. (Specify)					,,	City or Town, State)							
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	(Check only 2 Medical Exam	ysician: To the best o	examina	tion and/or in	vestigatio	n, in my o	pinion, deat	th occurred	at the time,	date and	place, and due t	to the cause(s)		
	To the To the Complet	Med	one)  29b. Signature and title of certifier	and manner stat	ea.		20	9c Licence	number			204 Dat	e signed (Month,	Day Veerl		
	F 3 6 8	_	200. Signature and the of certifier	W/ MD	>					1/		Zou. Dal	In I A	08		
	XP			, , , ,			_	700	اعانيا	10			12/20	00		
	2		30. Name and address of person who dalee	ompleted cause of de	ath (Item	23a) (Type,	Print)	REE	τ,	Hac	ers to	wn	e signed (Month,	21740		
	Sta Registr	te ar	31. Date filed (Month, Day, Year) DEC 3 0 2	008 32. Figistral	r's Signa	ture		Co								

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar		-	Certificate	of Death	Re	eg. No. 2001	3 43491	
I	Physicia	an	1. Decedent's Name (First, Middle, Last James M. Thompson					2. Date of Death Month December	25, 2008	3. Time of Death 6:50 am	
40	/Medic Examin		4a. Facility Name (If not institution, give	street and number)	· · ·		n, or Location of Deat	4c. County of Dea	ith		
2			Genesis Eldero  5. Social Security Number 6. Se		(In yrs. last birth		Lata ear   If Under 24 Hrs	. 9 Date of Birth	Charles	thplace (State or Foreign	
ā	Funeral Director		217–18–2094	ŽM 2□ F 85	· · ·		ays Hours Min.		Year) Co 1,1923 Ma	ryland	
Iryland 21215-0036 should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural"; or items 23a or 28a-1 show matic event, the Medical Exertiner must be notified at		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits		
	e Mary <b>3a-f sh</b> liffed	ctor	Maryland Charle	:S	Brya	ns Road				1 ☐ Yes 2 ☐XNo	
	with th	Director	10e. Street and Number			10f. Zip Co	de 516	10	U.S.A.	ountry?	
	death	Funeral	115 Gentry Ct.  11. Marital Status	12. Was Decedent E	ver in U.S.		of Hispanic Origin? (S Cuban, Mexican, Puer	Specify Yes or No-	14. Race - Am		
	ours after ral", or ite Exercine	by	1X Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1	0	1 ☐ Yes 2 ☐		to nican, etc.)	Black, Whit Specify: Wh		
	"natu	Completed	15. Decedent's Edu (Specify only highest grad	cation le completed)	16a. l	Decedent's Usual C Give kind of work of life DO NOT use I	eccupation lone during most of wo etired)	rking	16b. Kind of Business	/Industry	
	d withir giene. ir than	omo	Elementary/Secondary (0-12)	College (1-4or 5+	⊦) [		Mechanic	i	J.S. Gover	nment	
	< _ a e	Be	17. Father's Name (First, Middle, Last)					me (First, Middle, N Thompson	faiden Surname)		
Maryland	should be f and Mental I s marked of tumatic eve	မ	Norman Thompson  19a. Informant's Name/Relationship (T)	voe. Print)	19b	Mailing Address (S	treet and Number or R		City or Town, State.	Zip Code)	
ĭ Ma	es 1 and 2 should b of Health and Ment f item 27 is marked r other traumatic e		Francis Thompson	Brothe	r 29	05 Edgew	ood Rd., Br	ryans Road	•	•	
Θ.	Pages 1 and the pages 1 and the pages 1 and the page 1 and 1		20a. Method of Disposition 1		20b. Place of I cemetery	Disposition (Name ; crematory or othe arles Ce	pr Dec. 30	Date 2008	20c. Location - City or Indian Hea		
Balti	permit. Pages Department of Important: If ii any injury or once.		21. Signature of Funeral Pervice licens	1///	M00668	22. Name and A	ddress of Facility Funeral F	Home, P.A	•		
	402 6 6		23a. Part 1. Enter the disease, or compleshock, or heer that are. List only o			4270 Ha	wthorne Rd. f dying, such as cardia	, Indian	Head, Md.	20640 Approximate	
	Physician		shock, or he rt fai dre. List only o Immediate Cause (Final disease or condi	ne cause on each line	Co	chexi	a			Interval Between Onset and Death	
4	/Medical Examiner		resulting in death)	Due to (or as a	consequence of	): Nm.	1. Acelys		11		
ı		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a	t consequence of	110N-	newymi	ns ay	morhorus	<b>L</b>	
	ecuted ind transit	Examin	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	Approximinterval B  Ca Checkia  a consequence of):  Non-hodgkins S Xympho ma  a consequence of):  a consequence of):						
68760,	rtificate be executed ng physician and as the burial-transit		resulting in death) Last	Due to (or as a							
687	rtificate ng phy as the	<b>Nedical</b>	IE SCHALC:	J							
O. Box	The law requires that the death cer ate has been signed by the attendir age 2 should be detached for use	Physician//	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at 9 ☐ Unknown	2 🗌 Fetal death	3 ☐ Ectopic preg 5 ☐ Other (spec			23d. Date of de Month	elivery Day Year	
S, D.	es that tigned by	by Ph	Part II. Other significant conditions co	ntributing to death bu		id tobacco use contribute to the cause of death?					
Records,	requir been s thould									Probably 4 Unknown	
	The lavate has	Completed	-012					24a. Was ar autops perform 1 🗆 Yes 2	prior to death?	utopsy findings available completion of cause of	
Vital	> 07 T3	To Be	25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpatier	nt 2 ☐ ER/Out	patient 3 □ DOA	Other: \	eath (Check only one)  Home 5 ☐ Residence 6 ☐ Other (Specify)			
Division of	ding Phys h. After this funeral dir	on: T	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injur (Month, Day)	y 28b. Ti	me of 28c	Injury at Work?	28d. Describe how injury occurred			
isio	deat deat ctor: y the	ficati	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Inju	rv - At home, farr	m, street, factory, o	1 ☐ Yes 2 ☐ No	28f. Location (Street and Number or Rural Route Number,			
2	i gig i	Certification:	4 ☐ Homicide determined	building, etc.	. (Specify)	m, street, factory, o		City or Town	, State)	arar riosto riambol,	
	Hos 24 hr Fun etely	Medical (	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exam	vsiclan: To the best of iner: On the basis of and manner stat	examination and	death occurred at l/or investigation, in	the time, date and plac my opinion, death occ	e, and due to the ca urred at the time, da	ause(s) and manner a ate and place, and du	is stated. e to the cause(s)	
	To the within To the Comple	Ž	29b. Signature and title of certifier	1/2 Q	) ,,,,		cense number	I .	9d. Date signed (Mon		
•	A		30. Name and address of person who co	ompleted cause of de	path (Item 23a) (1	Type, Print)	006163	1 0	0	1200	
i	Sta	te	ATULKAT? 31. Date filed (Month, Day, Year)		ur's Signature	101, 6	1006163 POST 0/	tiu Ko	x, we all	MD MD	
	Registr		JAN 0 5 2	109 Sine	m B.	parker				V	

)8-09711 David Eugene V		lward	Type or I State of	Print in Blac Maryland / D	)epartme	ent of Hea	Ensure All Co alth and Ment	<b>opies A</b> al Hygie	re Legib ene	le. 20	08 43492
Physici		1- For State Registrar 1. Decedent's Name (First	, Middle,Last)		Certifica	ate of Dea	ath		Reg. Nate of Death		3. Time of Death
Medical Exami	iner	Davi	d E. W				y 2008 Year	1105 hrs			
		4a. Facility Name (if not in University Hospit	_	reet and number)			, Town, or Location of timore	f Death		4c. County of De	eath
Funeral Director		5. Social Security Number	132 M	7. Age (I	n yrs. last birth		nder 1 Year   If Under oths   Days   Hours	Min.	Date of Birth(M	Fo	Birthplace (State or reign Country) Washingt
пу		Usual Residence of Dece 10a. State 10b. C		10	c. City, Town	or Location			·		10d. Inside City Limits
nd Show a	_	MD		B	altimo	ore					1 X Yes 2 No
0036 within 72 hours after death with the Maryland giene. Net than "natural", or items 23a or 28a-f show any Medical Examiner must be notified at once.	Director	10e. Street and Number					Zip Code		109.	Citizen of What C	Country?
th the 23a or		1209 Myr	tle Av	renue	:-110	10 Wes Deed	21201 Ident of Hispanic Original	in? / Specify	Vec or No	U.S	A . merican Indian, Black,
ath wi	uneral	11. Marital Status  1 Never Married 2	Married	2. Was Decedent Ev Armed Forces?	er in U.S.	96 - If Yes, spe	dent of Hispanic Origi cify Cuban, Mexican,	Puerto Ricar	n, etc.)	White, etc	
fter de	ш	3 Widowed 4	1	X Yes 2 Yes, Give Year 07/	2000	1 Yes	2 X No specify:			Specify: b	lack
ours a	d by	15. Decedent's Education		nighest grade comple	eteo) 16a. I		al Occupation (Give k		lone 16	b. Kind of Busine	
nore, MD 21215-0036  ages I and 2 should be filed within 72 hours after death winn 10 Health and Mental Hygiene.  I: If item 27 is marked other than "natural", or items other tranmatic event, the Medical Examiner must be	Completed	Elementary/Secondary	(0-12)	College (1-4 or 5+)			rant wor			Priva	ato
21215-0036 und be filed within 7 Mental Hygiene. marked other than	luo	17. Father's Name (First,	Middle, Last)			Restu			t, Middle, Maic		ace
ID 21215-003 should be filed within and Mental Hygiene. 77 is marked other the matic event, the Med	Be C			1			Rot	t 17 R1	rko		
21, hould bend Men is mar	Tol	Willie Wo 19a. Informant's Name/Re	elationship (Type	e, Print )	198	o. Mailing Addre	ess (Street and Num	ber or Rural	Route Number	, City or Town, S	tate, Zip Code)
MD nd 2 sho alth and in 27 is		Willie Wo	odward	/father			et Rd Ba	1timo		D 2124	
ore, ME es I and 2 s of Health as If item 27 her trauma		1 X Burial 2 Cre			cremat	ory or other pla	ce)				
Baltimore, MC permit. Pages I and 2 st Department of Health at Important: If item 27 injury or other trauma			ther Specify:		MD_7	Vetera	ns Cemet nd Address of Facility	erv	1/7/0	9 Che	ltenham, MD
Ball permit Depart Impor		21. Signature of Funeral S	Service Licensee	- Na	7				Rd Su	itland	Md 20746
Physician		23a. Part I. Enter the dise			e death. Do no						Approximate Interval
/Medical		failure. List only one	_	line. unshot Wound	of Head						Between Onset and Death
* xaminer		Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):									
	_	Sequentially list condition			rance of the					· · · · · ·	
	nine	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause									
d sit	Examine	(Disease or injury that initiation events resulting in death)		e to (or as a consequ	ence of):						
executed in and 1 - transit	<u>~</u>	UNPENDED	d	MENDED		<u> </u>					
50, te be e ysicia	edi	IF FEMALE:		23c. If yes, outcome	of pregnancy					23d. Date of del	ivery
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be exwitin 24 hours after death.  To the Finneral Directors: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial.	Physician/Medic	23b. Was decedent pregn past 12 months? 1 Yes 2 No 9	ant in the	1 Live birth 4 Pregnant at tin	2	Fetal dea		pregnancy		Month	Day Year
Records, P.O. Box The law requires that the death cate has been signed by the arte page 2 should be detached for u	by Phy	Part II. Other significant	conditions co	entributing to death b	ut not resultin	g in the underly	ing cause given in Pa	ırt I.			e to the cause of death?  Probably 4 Unknown
Division of Vital Records, Isla or Attending Physician: The law requirer ar after death.  Director: After this certificate has been signed in by the funeral director, page 2 should be	Completed								24a. Was an autopsy performe	prior	e autopsy findings available to completion of cause of
<b>Rec</b> The la	E O								1 ✓ Yes 2		Yes 2 No
tal F ian: certifi	Be	25. Was case referred to examiner?		nital:			26.Place of Death				
F Vid Physic or this	[2	1 <b>Y</b> Yes 2	No	pital: 1 Inpatient		utpatient 3	DOA Other 4	Nursing Ho		sidence 6 C	Other:
noling of Afre	ii o	27. Manner of Death  1 Natural 5	Pending	(Month, Day Year Dec 23, 2008		3 hrs	1 Yes 2	Sub	ject was sl		
ISIO Atten r deat ectors	Certification:	Accident Pending Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or								r Rural Route Number, City	
Divi	ertif	3 Suicide 6 4 ✓ Homicide	Could not be determined	(Specify) Conv				1	or Town, State Bennett Place	e) ce, Baltimore, M	Md
Division of Vital    To the Hospital or Attending Physician: within 24 hours after death. The Finneral Director: After this certific completely filled in by the funeral director.	ŭ	29a. Certifier 1 Certif	fying Physician	: To the best of my k	nowledge, de	ath occurred at	the time, date and pla	ace, and due	to the cause(s	) and manner as	stated.
othe ithin 2 othe omplet	Medical	one) 2 Media	cal Examiner: O	n the basis of examin nd manner stated.	nation and/or i	investigation, in	my opinion, death oc	curred at the	time, date and	place, and due	to the cause(s)
F 3 F 8	₩ W	29b. Signature and title o		2 4-11-12			29c. License number		1		(Month, Day, Year)
		famely 9	Jouther	1, m)			O.C.M.E.			December 26	, 2008
4+1		30. Name and address of				- 444.5	nn Ctroot Dolth	ore MID	21201		
74		Pamela E. Souti		ssistant Medica		r 111 Pe	nn Street, Baltim	iore, MD	41401		
9	tate	31. Date filed (Month, Da. DEC 3 1 2	008	32. Registrar's	Jigrial Te						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. N2 0 0 8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Day Raymond Leroy Williams 4:00 P.M /Medical Jecember 27 2008 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Hagerstown Washington County 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Country) West **Funeral** 8. Date of Birth (Month, Day, Year)
July 30,1931 Days 233-50-9802 Director 77 Virginia Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar mart be natified at anone. 10c. City, Town or Location 10d. Inside City Limits Director Maryland Washington County Hagerstown 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14014 Marsh Pike 21742 U.S.A. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Completed by 3 Widowed 4 Divorced Specify: Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Nursing Assistant Hospital 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) James Archer Williams, Sr. Rosa Lee Enikes 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary F. Harris-daughter 318 N. Jonathan St. Hagerstown, MD 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Smithsburg Crematory 12-29-2008 | Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home Sunature of Funeral Service Licensee 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Rena hrowic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit physician and s the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Day Year 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 1 ☐ Yes 2 Z No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 A npatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 052323 12-29-2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1126 Opal Court Hagerstown, MO 21740

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)
DEC 3.0 2006

State of Maryland / Department of Health and Mental Hygiens, Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 27, 2008 3:11 A December Leone A. White /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Ft. Washington Hosptial Prince Georges Ft. Washington If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | March 26, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Year 1 □ M 2 K F 92 1916 Maryland 212-01-7700 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10a. State 10c. City, Town or Location ms 23a or 28a-f show 1 ☐ Yes 2 No Director Maryland | Prince Georges Accokeek 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 77 Farmington Road West 20607 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or Items 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🏋 No Specify Specify: White Completed by 3XXWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Director of Quality Control Navy Research Lab 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Harold Smith, Sr. Alice Leighter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health Important: If item 27 any Injury or other tr Farmington Rd. West, Accokeek, Maryland, 20607
Disposition (Name of Date 20c. Location - City or Town, State Terry Michael White 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location -1 ☐ Burial 2 XX Cremation 3 ☐ Removal from State **Huntt Crematory** Dec. 30, 2008 Waldorf, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Huntt Funeral Home mg1190 \$035 Old Washington Rd. Waldorf, MD. 20601 dications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. 23a. Part . Enter the disease, or conshock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) SHOCK SEPTL **Physician** /Medical Due to (or as a consequence of): **Examiner** LETA BOLIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, ENKOCH LON ? Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ DEMENTIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed VASCULA Access 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) examiner?
1 Yes 227 No
27. Manner of eath Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide e Hospital 24 hours a e Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier cal To the l 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of centifier 30145 1100505 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Samuel Kleimen 11711 Livingston Rd. Ft. Washington, Maryland, 20744 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

of the carety

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month December 2008 Stewart Wright 4b. City, Town, or Location of Death 4c. County of Death NICOME SALISBUM If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 6. Sex 1 X M 2 □ F Months Days Hours 75 5-5-1933 10c. City, Town or Location 10h County

1 - For State Registrar 1. Decedent's Name (First, Middle, Last) **Physician** 22:04M Theodore /Medical 4a. Facility Name (If not institution, give street and number) Examiner ENINSULA XEGIONAL Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Connecticut Director 214-30-8961 Usual Residence of Decedent 10d. Inside City Limits 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the "hedical Examiner must be notified at once. 1 ☐ Yes 2 X No Director Wicomico Parsonsburg MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21849 USA 6575 Forest Grove Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No 195 If Yes, Give Year or Dates: 195 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐ Never Married 2 ☑ Married 1953-3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White ò 3 ☐ Widowed 4 ☐ Divorced 1955 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Food Transportation Milkman 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ruth Adelaide Glover Wright Russell Otis 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 6575 Forest Grove Road, Parsonsburg, MD 21849 Peggy Wright - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 1-3-2009 Parsonsburg, Maryland Jerusalem Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature 22. Name and Address of Facility Bounds Funeral Home Funeral Service Licenses 705 E. Main Street, Salisbury, Maryland 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ARDS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Segui Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 D Ectopic pregnancy in the past 12 months? Month Year Day 4 ☐ Pregnant at time of death 5 Other (specify) P.O. | ed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by t be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an certificate has The 2 No 2 No 1 ☐ Yes Division of Vital Physician: 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Attending 1 Natural 5 Pending To the Hospital or Attendil within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No death. 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

JohERT 31. Date filed (Month

00 COKER Year, JAN05

CARNOLL

SALISBURY Md

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar #31 per hd, 1/5/09, s1 Certificate of Death Amend item Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month Year **Physician** 2:25 2008 4a. Facility Name (If not institution, give speet and number, /Medical 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Trisfield

If Under 1 Year | If Under 24 Hrs. 8. Date of Birth

Months Days Hours Min. Month, Day. Somers Love 45 MERSEN 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 1 M 2 ☐ F 7. Age (In yrs. last birthday) **Funeral** 214 52 0938 57 Yrs. Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examinating Item Milled at once. Cristicald 1 Nes 2 □ No Somerset Maryland Director 10f. Zin Code 10g. Citizen of What Country? 10e. Street and Number 45 Somers Instead States of america 21817 Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces 1 ☐ Yes 2 0 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 □ Yes 2 100 Baltimore, Maryland 21215-0036 Specify: 3 Vidowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry of Crist Elementary/Secondary (0-12) College (1-4or 5+) Labover 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Year 1 White nomas 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Minton MD 9109 prina 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20c. Location - City or Town, State 20a. Method of Disposition 1 □ Burial 2 ViCremation 3 □ Removal from State Mar Jan 12, 2009 Salisbury 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature A Puneral Service Licensee thony E Funeral Approximate Interval Between Onset and Death 23a. Part! Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Mero (RANS /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examiner burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical be detached for use as the IF FEMALE: If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 3 Probably 4 Unknown funeral director, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2Z No 1 Yes 2 🗆 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: 4 Nursing Home 5 esidence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide To the Hospital o within 24 hours af To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely

201 31. Date filed (Month, Day, Year) 2009 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

Registrar

29c. License number

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 8:53 a M 2008 KENNEDI WILSON DECEMBER 16, BRAILYN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGES PRINCE GEORGES HOSPITAL CENTER CHEVERLY 8. Date of Birth (Month, Day, Year)
Oct. 26,2008 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days 20 Months 1 □ M 2 🖾 F Washington, DC 1. Director 579-47-5035 Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits 10b. County 10a State 28a-f show 7 is marked other than "natural", or Items 23a or 28a-f sho traumatic event, Inc Modical Erra i incrinust be notified at XTYes 2∏No Director D.C. Washington 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number death with 20002 United States Funeral 1254 Penn St., N.E 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or Itel 1 ☐ Yes 2X If Yes, Give Year or Dates: 1X Never Married 2 Married 2**X** No altimore, Maryland 21215-0036 1 ☐ Yes 2x ☐ No Specify: 2 3 ☐ Widowed 4 ☐ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) N/A N/A 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nia Wilson မ Keith Gross 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health an Important: If item 27 is any Injury or other trau Alecia Wilson/Grandmother 1254 Penn St., NE Wash., DC 20002 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 12-19-08 Harmony Memorial Park Landover, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Capitol Mortuary, Inc. of Funeral Service License 20002 1425 Maryland Ave., NE Wash., complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, shock, or heart failure. Li Immediate Cause (Final **Physician** TRISOMY 18 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner VENTRICULAR SEPTAL DEFECT Sequentially list conditions, if any, leading to infine liab cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examiner be executed FATAL CARDIAC ARRHYTHMIA burial-tran Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical law requires that the death certificate IF FEMALE yes, outcome of pregnancy

☐ Live birth 2 ☐ Fetal death
☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) P.O. the a detached 9 Unknown cate has been signed by page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 **X**No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Division of Vital 9 Hospital or Attending Physician: 24 hours after death.
9 Funeral Director: After this certifica 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 🏖 ☐ No 1 X Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 1 Anatural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a, Certifier [X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basic of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one To the twithin 2. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D25675 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) , M.D. 20785 Frederick Corder 3001 Hospital Dr. Cheverly, Md. 32. Registrar's Synature 31. Date filed (Month, Day, Year State JAN 1 6 2009 Registrar

		State of Maryland / Dep	artment of Health and Nertificate of Death		ne No.2008	43498					
Physicia		1. Decedent's Name (First, Middle, Last) Samuel Ackerman		2. Date of Death	<sup>□</sup> 370, 2000′8	3. Time of Death					
/Medica Examine Funeral Director	r	4a. Facility Name (If not institution, give street and number)  Holy Cross Hospital  5. Social Security Number  6. Sex   7. Age (In yrs. last birthday)  7. Record   7. Age (In yrs. last birthday)  7. Record   7. Age (In yrs. last birthday)  7. Record   7. Age (In yrs. last birthday)	4b. City, Town, or Location of Death  Silver Spring  If Under 1 Year   If Under 24 Hrs.  Months Days Hours Min.	Silver Spring Mon							
Imore, Maryland 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: if item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the health Instruction in the configuration.	be completed by Funeral Director	Usual Residence of Decedent  10a. State	ocation  a  10f. Zip Code 20814  Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 □ Yes 2 No Specify:  edent's Usual Occupation s kind of work done during most of work DO NOT use retired)  ner  18. Mother's Name Anna H  ing Address (Street and Number or Rur  8 Custer Road Beth	e (First, Middle, Maiconikman al Route Number, Citesda MD 20 Date 20c	Citizen of What Coun nited Stat  14. Race - Americ Black, White, e Specify: W  Liquor Re den Surname)	Od. Inside City Limits  TYPE 2 No					
Physician /Medical Examiner	Yallille	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death)  Due to (or as a consequence of):  Due to (or as a consequence of):									
BOX 68/60	Completed by Physician/Medical E		□ Ectopic pregnancy □ Other (specify)  Inderlying cause given in Part I.	23e. Did tobacc 1 □ Yes 24a. Was an autopsy performed' 1 □ Yes 2 <b>X</b>	co use contribute to th	e cause of death?  ably 4 🖾 Unknown  asy findings available apletion of cause of					
VIII	25. Was case referred to medical examiner?  1										
To the Hospital Within 24 hour To the Funers completely fills		29a. Certifier (Check only one)  1 ★ Certifying Physician: To the best of my knowledge, deal control on the basis of examination and/or in and manner stated.	29c. License number D33357	ed at the time, date a	e(s) and manner as st and place, and due to Date signed (Month, L ecember 31	the cause(s)  Day, Year)					
State Registrar		30. Name and address of person who completed cause of death (Item 23a) (Type,  Lee Jonathan Musher up 55  31. Date filed (Month, Day, Year) 32. Registrar's Signature	30 Wisconsin Aue	Sut 104	15 Chery	Chase mn					

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1 Month 20ď8<sup>8</sup> 30 11:36 A M Paul Joseph Alfonsi 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Peninsula Regional Medical Center Salisbury Wicomico 5. Social Security Number (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Days Hours 9/211/1932 MD 213-30-7148 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 1 ☐ Yes 2 No Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 432 Rolling Rd. 21801 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 [∄Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married 1 □Yes 2 No Specify: white 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Aerospace Engineer NASA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anthony J. Alfonsi Katherine Barona 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christine M. Alfonsi / daughter 33041 Vines Creek Rd., Dagsboro, DE 19939 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Sunset Memorial Pk. 1/3/2009 Berlin, MD 21811 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ligense 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on Immediate Cause (Final disease or condition resulting in death) Due to (or es a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 \(\times\)No

**Physician** /Medical Examiner

**Physician** 

Examiner

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examinar must be particled.

Baltimore, Maryland 21215-0036

/Medical

Director

by Funeral

Completed

Be

ပ

MD

Exami physician and the burial-tran Physician/Medical attending p as asn signed by the aid Completed by cate has been si page 2 should b this certificate within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. Be Certification: To

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

IF FEMALE: 23b. Was decedent pregnant In the past 12 months? ☐Yes 2☐No 9 Unknown

						, , , , , , , , , , , , , , , , , , , ,				
25. Was case referred to medical examiner? 1 ☐ Yes 2 【XNo		26. Place of Death (Check only one)								
		Hospital: 1 1 Inpatient 2	] ER/Outpatient	3 🗆 D	Home 5 ☐ Residence 6 ☐ Other (Specify)					
7. Manner of Death 1 XNatural 2 Accident	5 ☐ Pending investigation		28b. Time of Injury	м	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury occurred				
3 Suicide 4 Homicide	6 ☐ Could not be determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, stree	t, factor	ry, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	17									

29a. Certifier

29b. Signature and title of certifier

1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year) 12.30 5

Suke 605 Colisbuy my 2114

30. Name ar of person who completed cause of death (Item 23a) (Type, Print) BAIDTI

State Registrar 1. Date liled (Month, Day, Year) JAN 06 Registrar's Signature

To the within 2

08-09762 Kaylee Bentz Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2008 43500 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Day December 27, 2008 **Medical Examiner** 1020 hrs Kaylee Ranae Bentz 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Frederick Memorial Hospital Frederick Frederick 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Hours Director 216-83-3763 2 X F Country) Maryland М Nov. 14, 2008 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits is marked other than "natural", or items 23a or 28a-f show after event, the Medical Examiner must be notified at once. 1 X Yes 2 No Maryland Frederick Walkersville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 Charles Street 21793 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc. White, etc. 1 X Never Married 2 2 X No Yes If Yes, Give Year Divorced Yes 2 X No specify: Specify: White ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) , MD 21215-0036 and 2 should be filed within 72 ealth and Mental Hygiene. 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Todd Bentz Mary Katherine Shoemaker ۵ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i Pages 1 and 2 sl nent of Health ar Todd Bentz - Father 9 Charles Street, Walkersville, Maryland Baltimore, I permit. Pages I and Department of Healt Important: If item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 2 Cremation 3 Removal from State Glade Cemetery 12-31-2008 Walkersville, Maryland ajure of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home Opossumtown Pike. Frederick, Maryland 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** failure. List only one cause on each line. Between Onset and /Medical Death Immediate Cause (Final disease Sudden unexplained death in infancy (SUDI) kaminei or condition resulting in death) Due to (or as a consequence of). Sequentially list conditions Due to (or as a consequence of) Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit Physician/Medical 23a,P11,2/,28a-f, perME, G889 3/9/09 TT AMENDED XUNPENDED the attending physician led for use as the burial Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Fetal death Day Year past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 V No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Yes 2 No 3 Probably 4 V Unknown Congenital narcotic dependency Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of has t death? this certificate ✔ Yes 2 1 🗸 Yes To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medica 26.Place of Death (Check only one) Be examiner? Hospital: Other<sub>4</sub> Inpatient 2 FR/Outpatient 3 DOA Nursing Home 5 Residence 6 1 ✔ Yes 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural Yes 2 X No unk Pending To the Funeral Director: the 12/27/08 Fd 10:00 Accident Investigation filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number of Rural Route Number, City 6 X Could not be Suicide or Town, State) house determined Walkersville, Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. December 28, 2008 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Pay, Year) 5 REC'T 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

RASIAS

DOME